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ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND  
RELATED MATTERS.

*Rowe: in Ch.*

Hearing held in Court Room 20  
Court House  
361 University Avenue  
Toronto, Ontario

The Honourable Mr. Justice **S.G.M. Grange**

Commissioner

**P.S.A. Lamek, Q.C.**

Counsel

**E.A. Cronk**

Associate Counsel

**Thomas Millar**

Administrator

Transcript of evidence  
for

July 14th, 1983

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Court House, 361 University  
Avenue, Toronto, Ontario, on  
Thursday the 14th day of July,  
1983.

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner  
THOMAS MILLAR - Administrator  
MURRAY R. ELLIOT - Registrar

APPEARANCES:

P.S.A. LAMEK, Q.C.	Commission Counsel
D. HUNT ) L. CECCHETTO)	Counsel for the Attorney- General and Solicitor General of Ontario (Crown Attorneys and Coroner's Office)
I.G. SCOTT, Q.C.) I.J. ROLAND ) R. DEVINS )	Counsel for The Hospital for Sick Children
D. YOUNG	Counsel for The Metropolitan Toronto Police
W.N. ORTVED	Counsel for numerous Doctors at The Hospital for Sick Children
B. SYMES	Counsel for the Registered Nurses' Association of Ontario and 35 Registered Nurses at The Hospital for Sick Children

(Cont'd)







APPEARANCES: (Continued)

H. SOLOMON	Counsel for the Ontario Association of Registered Nursing Assistants
W.A. BOGART	Counsel for Susan Nelles - Nurse
G.R. STRAHTY)	Counsel for Phyllis Trayner - R.N.A.
B. JACKMAN	Counsel for Mrs. M. Christie - R.N.A.
J.A. OLAH	Counsel for Janet Brownless (Vereecken) - R.N.A.
M. MANNING, Q.C.	Counsel for Mr. & Mrs. Gosselin, Mr. & Mrs. Gionas, Mr. & Mrs. Inwood, Mr. & Mrs. Turner, Mr. & Mrs. Lutes and Mr. & Mrs. Murphy (parents of deceased children)
F.J. SHANAHAN	Counsel for Mr. & Mrs. Dominic Lombardo (parents of deceased child Stephanie Lombardo); and Heather Dawson (mother of deceased child Amber Dawson)
W.W. TOBIAS	Counsel for Mr. & Mrs. Hines, (parents of deceased child Jordan Hines)
J. SHINEHOFT	Acting for Lorie Pacsai and Kevin Garnet (parents of deceased child Kevin Pacsai)





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---Upon commencing at 10:00 a.m.

THE COMMISSIONER: Yes, Mr. Lamek.

MR. LAMEK: Thank you,  
Mr. Commissioner. Dr. Rowe, please.

DR. RICHARD DESMOND ROWE, Resumed

DIRECT EXAMINATION BY MR. LAMEK: (Continued)


Q. Dr. Rowe, before we go any further in your evidence there is something that I understand you want to clarify or correct from yesterday's evidence and I think it is proper that you do that. Towards the end of the day yesterday, and Mr. Commissioner, this is at page 1935 of yesterday's transcript, and speaking about the Velasquez child, I put this question to you, Doctor:

"I don't know, Doctor, if, since August 25th, 1980 you have been asked this question but I have to ask you: were the terminal events recorded in the chart of this child consistent with digoxin intoxication?

A. Yes.

Q. That is to say, a measure of arrhythmia, slowing of the heart seizure-like activity?

A. Yes."



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3 Now, I understand through your counsel,  
4 Dr. Rowe, that there is something you want to say  
5 about that and I think it proper that you say it now  
6 and correct any misimpression that you may have  
7 given yesterday with that answer.

8 A. Well, yes, the answer "yes"  
9 is that that series of events could occur with  
10 digoxin but it is most likely due to, or at least  
11 is possibly due to other factors as well.

12 Q. I am sorry, I want to be  
13 fair, I am looking at the whole course of events  
14 which as you recall, and we can check the chart if  
15 necessary, was an administration of a dose of  
16 naloxone.

17 A. Yes.

18 Q. That was larger than recommended,  
19 but nevertheless a dose of naloxone.

20 A. Yes.

21 Q. Given to a child who appeared  
22 to be suffering from, not suffering, affected by the  
23 codeine that he had received.

24 A. Yes.

25 Q. And a response by the child  
to the naxolone, but by the doctor  
considered not yet a sufficient response and then





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an administration of a further dose of naloxone,  
following which the child displayed certain symptoms  
and almost immediately arrested.

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A. Yes.

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Q. Now, is that sequence of  
events consistent with digoxin intoxication is  
essentially my question?

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A. Well, it is possible that it is,  
but it is also possible that there might be, it might  
be related to the drug itself.

11

12

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Q. Yes, of course. Okay. I'm  
sorry, then I hadn't really misunderstood your answer  
yesterday?

14

A. No.

15

16

Q. I understood you were now  
attaching some significance to the response to the  
initial dose of naloxone.

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A. The reason I say that is  
because the response to naloxone caused the heart  
rate to improve and one might not expect that if it  
was digoxin intoxication.

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Q. You cannot tell me that it  
would not happen?

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A. No, I could not say it would  
not happen.







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THE COMMISSIONER: Did you say the naloxone, whatever other name you used was administered, did you say it improved the heart rate?

THE WITNESS: It improved the heart rate and that would be less likely to occur if there were digoxin as a basis for the slowing and so on.

MR. LAMEK: Q. Dr. Rowe, I hope I am being fair about this, and I don't want to take that answer any further than it is capable of going. Do I understand you now to be saying, and please tell me if I am misstating this, do I understand you now to be saying that the sequence of events and the symptoms and responses of baby Velasquez in the last few minutes of his life may be consistent with digoxin intoxication, but you would rather doubt it in light of the response in increased heart rate to the first dose?

A. Yes.

Q. Thank you.

THE COMMISSIONER: I'm sorry, I don't quite understand that because the naloxone is designed to improve the heart rate is it not, isn't that the purpose of it, or is its purpose to counteract the codeine.

THE WITNESS: The purpose is to







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counteract the effects of the codeine.

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MR. LAMEK: Q. Perhaps I could

ask this question, Mr. Commissioner, I think the  
same thing is bothering me. If the slowed heart  
rate were, as was believed, the result of a response  
to codeine, and I take it one could assume that  
codeine has an affect, either directly on the heart  
or via the central nervous system upon heart rate?

A. Yes.

Q. And therefore naloxone in  
counteracting those effects I take it must similarly  
be taken to have an effect either directly on the  
cardiovascular system, which is thought not to be  
the case, or upon the central nervous system that  
is indirectly affecting the heart rate.

A. Yes.

Q. And if therefore naloxone is  
capable indirectly of affecting the heart rate,  
is that the reason that you cannot categorically say  
these events are inconsistent with digoxin  
intoxication?

A. I am not sure of the full  
answer to that. I think you would have to ask a  
pharmacologist, our pharmacology friends to do that.

Q. Okay.





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A. But that was my clinical  
impression on surveying the data.

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Q. The question has been raised  
in your mind and it is proper you voice it for us,  
Doctor, and we will take that up with the pharmacolo-  
gists.

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We have one more of the cases to  
consider that were reviewed at the September 26th  
meeting, and that was the case of Kelly Ann Monteith,  
and there is behind you on the easel a diagram,  
Dr. Rowe, a diagram that purports to be the heart  
of Kelly Ann Monteith. Are you able to tell me  
whether from your review of the chart the diagram  
accurately depicts the state of that child's heart?

15

A. Yes, it does.

16

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MR. LAMEK: May that, Mr. Commissioner,  
be the next exhibit.

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---EXHIBIT NO. 63: Diagram of Heart of Kelly  
Ann Monteith.

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MR. LAMEK: Q. Now, Doctor, we  
are treading the now reasonably well worn path, but  
could you describe for us first please the anatomy  
of that heart and the defects and deformities which  
existed in it and tell us something of the clinical







1  
2 significance of those defects?

3                   A.           Yes. The primary problem in  
4 this child's heart is not in the structural arrange-  
5 ment of the pump, but in the fact that there is an  
6 abnormal position for the origin of the left main  
7 coronary artery. We haven't diagramed it on the  
8 normal, but both the right coronary artery and the  
9 left coronary artery in the normal individual arise  
10 just above the aortic valve in the aorta on the left  
11 side of the arterial trunk. Those arteries pass on  
12 the left side mainly to the left heart and on the  
13 right side mainly to the right heart. There is  
14 some communication between the two sides. But the  
15 blood supply to the heart muscle which is resulting  
16 from the normal supply is distributed under systemic  
17 pressure, that is under the pressure in the aorta  
18 and passes through the entire muscular portion of  
19 the pump. That supply is necessary to maintain an  
20 integrity of the function of the heart and its  
21 electrical activity.

22                   The condition which Kelly Ann  
23 Monteith had was one in which the right coronary  
24 artery arises in the usual fashion from the aorta  
25 as is shown here. So this is a diagram demonstrating  
a normal distribution of the right coronary artery to





1  
2 the right side of the heart. The left coronary,  
3 however, which predominantly supplies the muscle  
4 of the left ventricular or main pumping chamber,  
5 arises not from the aorta at all but is arising from  
6 the back end of the pulmonary artery just above its  
7 valve. What that produces is no difficulty during  
8 life in the womb to any great extent. It may  
9 produce difficulties in the latter part of the  
10 pregnancy but probably not gross disturbance of  
11 function. Because during that time the heart acts  
12 like a single pump because of that matter of the  
13 ductus arteriosus that I mentioned before and  
because the lungs are not expanding.

14 Immediately after birth when the  
15 pressure in the pulmonary artery starts to fall  
16 after the ductus begins to constrict, and therefore  
17 this side of the heart becomes a low pressure  
18 slurping type pump, then the perfusion of this artery  
19 from the pulmonary artery stops, because it is not  
20 enough to send the blood all the way through a  
21 chamber with which it is contracting systemic  
pressure.

22 So what then develops is a serious  
23 problem of ischemia, or lack of oxygen supplied to  
24 the muscle of the left ventricular, and the degree to  
25







1  
2 which that happens depends on a number of individual  
3 features in any individual with this condition.

4 The right coronary artery enlarges  
5 enormously because it is the only artery that can  
6 take blood into the system, and small branches, which  
7 are collateral vessels between the coronary systems,  
8 they are very small branches, that unite the two  
9 systems at the periphery of the arteries will  
10 communicate with this branch here, so that blood  
11 then goes from this artery supplies the muscle on  
12 the right side and then branches will carry through  
13 over to this side. Blood will then go off up here  
14 and be siphoned as it were into the pulmonary artery.  
15 That means that there is continuing progressive  
16 damage but that it may be modified by how much blood  
17 can enter the system from the other side.

18 Obviously if none could get across  
19 then within a week or two the baby would die. But  
20 when some can get across as it often does, although  
21 it may be a relatively small amount, then some of  
22 that on its way up here will nourish the muscle of  
23 the left heart.

24 The disturbance therefore that  
25 happens on the whole and in the majority of these  
patients it occurs early, is that they develop





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breathing difficulty because of left heart failure,  
that is this whole ventricular or pump becomes subjected  
to ischemic damage which is more or less the same as myo-  
cardial infarction in an adult. It is just as if you  
had plugged this coronary artery with a clot. But  
it is modified so that it is a gradual and repetitive  
process and small bits of muscle die all the time.

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But eventually the chamber becomes mostly dead muscle and then all that is left is a very thin amount of muscle which cannot possibly cope with the work that the left pumping chamber is supposed to do.

In addition, the muscular apparatus that supports the mitral valve becomes damaged by this ischemic process and mitral regurgitation, meaning leakage back with each squeeze of the pump into the receiving chamber of the left atrium becomes important and that in itself can produce massive enlargement of the left atrium, as it did with this baby.

In fact, the principal presenting symptoms to the family doctor in this situation were that this baby appeared to have obstructed breathing and that was because the whole of the top left chamber, the left atrium was so enlarged that it was compressing the left main stem bronchus, that is, the main respiratory passage or tube to the left lung.

The treatment of this condition is initially that of treatment of the heart failure, but the fundamental intervention would have to be surgery.

The theoretical approach would be to transplant or transpose, not transplant, transpose





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the anomalously placed coronary artery from the pulmonary artery back to where it should be in the aorta. The difficulty in doing that is the fact that the diagnosis is seldom realized until the baby has had substantial death of heart muscle, so that the risk of doing such an operation, especially in a very small baby, is extremely high.

Other approaches have been suggested which simply mean tying off this artery, and that was the original operation available in which the artery is tied off here, and that means that blood can't syphon back into the pulmonary artery and, therefore, there is more opportunity for it to profuse or supply and nourish the muscle. But again, that is dependent upon how much of these collateral bypasses are in effect, and particularly since there is a tendency for those to close down for some time after birth before being opened up again.

So, the mortality with this condition is high and the survivors are those of whom there is a surviving amount of muscle for one reason or another, usually related to the collateral supply. In the ordinary course of events, with relatively modest collateral flow, these babies do very poorly indeed and usually succumb, and the difficulty is that even







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if you can get them to operation, most of them will  
die during the procedure.

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It is a very disturbing and  
problematical issue.

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Q. Doctor, thank you. The  
minutes of the meeting of September 26 contain a  
rather terse summary of the condition of Baby  
Monteith, and you have expanded upon that considerably  
for us. Indeed, the manuscript notes of that meeting  
really don't add very much to what was said about  
Baby Monteith on the 26th of September.

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But it does appear, does it not,  
that the baby did go for cardiac catheterization and  
some 16 hours after that, according to the manuscript  
notes, I assume this was discussed at the meeting,  
the heart went into ventricular fibrillation and the  
baby died?

17

A. Yes.

18

19

Q. And Baby Monteith died in the  
early morning of August the 19th, 1980, I believe?

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A. Yes.

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Q. Now, she had been scheduled  
to have an operation on August the 21st, hadn't she?

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A. I believe that is so.

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Q. Yes. And that I think is

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referred to in the reporting letter on page 12 of the chart. 12 is not easily legible because it is printed right over the words on the page "Chart Copy". There is a letter dated August 18, 1980 written by Michael Shaffer , Cardiology Fellow for Dr. Olley to Dr. Verbeek, who I take it was the referring physician?

A. Yes.

Q. And in the penultimate paragraph of the letter, Dr. Shaffer reports that:

"Kelly Ann Monteith was discussed at our cardiovascular surgery conference and with the above findings it was felt that she would benefit from an attempt to repair the anomalous origin of the coronary artery and she is presently scheduled for corrective surgery on the 21st of August, 1980."

I take it that it was proposed that an operation of the kind you described, to relocate the origin of the coronary artery, was proposed?

A. Yes.

Q. And that decision, as I understand it, was made at the surgical conference that





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was held on August the 18th, that is to say, the  
date of Dr. Shaffer letter, the day before the  
baby died?

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A. And that was following the  
cardiac catheterization that morning.

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Q. Following catheterization,  
that's right. Catheterization in the morning,  
surgical conference that same day and the decision  
to schedule her for surgery on the 21st and Shaffer  
wrote reporting the status of the matter to the  
referring physician?

12

A. Yes.

13

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Q. And you have told us that the  
surgery that was proposed for the Monteith baby had  
to be considered high-risk surgery?

15

A. Yes.

16

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Q. Because of the nature of her  
particular ailment?

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A. Yes.

19

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Q. And the damage that she may  
already have sustained as a result of that  
deformation?

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A. Yes.

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Q. Had any thought been given to  
scheduling her for surgery before August 21st?







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A. I expect that is so. I don't know for sure, one would have to ask those who are responsible at the time because I can't see any evidence of that here. I would think, judging from the usual procedure, that this youngster would be regarded as an urgent case, that they probably would not want to do it the same day as the cardiac catheterization but they would be trying to fit the baby into the schedule on an emergency basis.

Q. Yes. And would you normally consider an emergency basis something less than three days hence?

A. Well, it would depend upon the situation at the time. If the surgeons can fit it in they would. If they thought stabilization was worth pursuing, they might say no. They would have to make a number of judgments on that and I think you would have to ask them as to what the reasons might have been in this particular instance.

Q. Well, I recognize there may well have been scheduling problems, OR time and surgeons' time, although, I take it that of necessity there is some flexibility in their system to take care of a truly emergency situation?

A. Oh, yes.





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Q. But the scheduling of surgery for the 21st of August, that scheduling having occurred on the 18th, does suggest, does it not, that it was at least contemplated that this baby would survive until the 21st?

A. I don't think that we could make that assumption in a baby with this condition. I think that this sort of baby is liable with ischemic damage to continuing infarction at any time and I think that we couldn't assume that everything will be all right for several days; from the medical standpoint I'm talking about.

Q. Yes. Is it of significance that the baby was two months old at that time and that with this structural defect in the heart, this anatomical defect, she had nonetheless survived for two months. Did that suggest that in fact in one way or another there was some reasonable ~~per~~<sup>er</sup>fusion of the right side of the heart to have been able to have survived that long?

A. I'm not sure that I would agree with the term "reasonable" because the baby had been in difficulty for some time.

Q. Yes.

A. But there was enough to allow the baby to survive, to be sure.







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Q Well, once again, we have got language by Dr. Freedom, that I suppose he himself will have to answer for - not answer for but to explain - but on page 13 of the chart there is Dr. Freedom's reporting letter to Dr. Verbeek, dated August 19th. This was the day following the night in which Kelly Monteith died, and in his second paragraph he says:

"As I mentioned to you, she was discussed at our Surgical Conference on August 18th, and it was felt that she would be a candidate for some type of surgical procedure to re-direct her coronary artery to her aorta. Certainly with a severe and global impairment of her left ventricular function, she was considered a high risk, and as you know by this time she died suddenly early in the morning of August 19th." Now, maybe suddenly is not so difficult a word to describe as unexpectedly?

A. Yes.

Q But I take it we'll agree that the death of this baby was sudden when it occurred?





BB.9

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A. Yes.

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Q. And am I right in my reading

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of the chart, Doctor, that findings at autopsy

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revealed a more serious condition than had been

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suspected?

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A. The findings at autopsy

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revealed more extensive myocardial destruction than

9

had been anticipated, although, I don't think anybody

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was under the impression that there was only a little  
bit of myocardial destruction.

11

Q. And as Dr. Freedom reports

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in his letter of August 19th, really, the chances of

13

her surviving surgery have been very slight indeed

14

in light of what was discovered on autopsy. Is that  
fair?

15

A. I would probably go further

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and say there was probably no chance.

17

Q. But that of course wasn't

18

known in its full detail and to its full extent as

19

at the time of scheduling the child for surgery?

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A. No.

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Q. And for one reason or another

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surgery was scheduled for the 21st and the baby

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didn't make it into the operating room?

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A. Correct.

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Q Now, may I refer you again to the report of Dr. Bain, and I will put this before you, Doctor, if you look at page 6 of that report. I'm sorry, do you have the report with you today?

A No, I don't have it with me, I'm sorry.

Q At page 6 of the report, referring to Kelly Ann Monteith, Dr. Bain refers to her deformation and says:

"She was placed in this category ... " that is this category for comment by him:

" ... because there was some feeling prior to the post mortem that perhaps she should not have died when she did. At post mortem she had very severe heart disease and was really not compatible with life.", he says.

But I am directing my attention, Doctor, to the state of knowledge of the surgeons and the cardiologists while this baby was still alive.

Was it your understanding, as Dr. Bain seems to record, that there was some feeling prior to post mortem that Kelly Ann Monteith perhaps







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should not have died when she did. Was there a  
measure of surprise that she died just when she did?

A. I think a number of people  
may have suggested that. I can't recall exactly, but  
I would imagine, because she was talked about in our  
conference.

Q. Yes.

A. That there had been some  
concern on the part of nurses that perhaps she should  
not have died. I think the problem that enters into  
that aspect is the ability of not the question of  
deciding the diagnosis, but the ability of being able  
to assess the extent of the myocardial infarction.

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Q. The baby was originally admitted to Ward 4A on August 14th, as I understand it?

A. Yes.

Q. And was transferred the same day to the ICU?

A. Yes.

Q. And that appears at page 38 of the chart in the progress notes.

The first note records that at 7:45 p.m., the baby having been admitted to 4A was ordered transferred to the ICU. And I take it that reflects a measure of concern about the baby at that stage and the baby being in some measure of difficulty?

A. And I think - that is true, but as well there is a background here of there having been thought to be a condition known as a vascular ring.

Q. A vascular?

A. Ring, r-i-n-g.

Q. What is that?

A. Congenital condition in which the aorta, instead of being a single vessel going up and around and down, splits into two portions and surrounds the trachea or major windpipe.

Q. Yes.

A. And so compresses it. And the







1  
C 2 2 symptoms in this baby had been of such a nature in  
3 terms of difficulty breathing and noisy breathing  
4 that the family physician was concerned that that  
5 might be the diagnosis.

6 For that reason I think everybody was  
7 primed to the possibility that this baby might need  
8 intubation, and I think as I read that - I can't be  
9 sure - but I would think that that might have had  
10 some influence on the decision to transfer.

11 Q. Yes?

12 A. And I believe at some stage  
13 Dr. Freedom did mention that to me.

14 Q. All right. It appears from page  
15 41 of the chart Doctor, again, in the progress notes,  
16 that having spent the night in the ICU the baby went  
17 back to the ward on August 15th?

18 A. Yes.

19 Q. And appeared then to be in a more  
20 stable condition?

21 A. Yes. I think that is what the  
22 notes say.

23 Q. Yes. The nursing notes certainly  
24 on the 15th and 16th suggest, do they not, that the  
25 baby is now more stable?

A. Yes.





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Q. It was on digoxin and lasix. On page 41 the note of 15/8/80, a third of the way down the page:

"Returned from ICU at 1400 hours.  
Vital signs stable. Babe's  
irritability much less problem.  
Heart rate down, blood pressure  
stable, colour good, chest no  
wheezing now."

A. Yes.

Q. And the stay in the ICU appears to have been beneficial to the child?

A. Yes.

Q. And essentially the same pattern occurs in the nursing note, does it not, through the 17th and 18th of August?

A. Yes.

Q. The continuing report appears to be of stability at the present time?

A. Yes.

Q. Page 47 of the chart there is a note as to the terminal events and the resuscitation attempt.

At 3:40 in the morning on the 19th there





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was a Code 25 to this baby. Brief history at the beginning of the thing.

A. Yes.

Q. And apex - is that irregular?  
I can't read it very clearly. I am afraid it's not a very good copy.

A. I can't read it either.

Q. All right. In light of what comes later it may not be a bad guess because it says a little later the monitor showed ventricular fibrillation?

A. Yes.

Q. What is recorded by way of symptom and event, as I read this, and I would be grateful for your help, Doctor, is some observation as to the apex pulse, pupils dilated - do I read that correctly, immediately below that line?

A. Yes.

Q. Ventricular fibrillation?

A. Yes.

Q. To which the child reverted after there had been some attempt to resolve that.

And then sinus bradycardia.

If I look at page 49 of the chart as well I believe there is another symptom there. At







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3:30 in the morning, immediately before this Code 25,  
Nurse Nelles reports or records:

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"Babe again vomitted approximately 15  
ccs of bile fluid ... child appeared  
to stiffen and eyes began to roll in  
her head ... seizure like activity."

5

6

7

Is that right, Doctor?

8

A. Yes.

9

Q. And then we have got ventricular  
fibrillation, irregular heart rate, bradycardia and  
a failure to resuscitate?

10

11

A. Yes.

12

13

Q. And fairly, once again, I think  
one can say those terminal events took a rapid course?

14

A. Yes.

15

16

Q. Now I know I have asked you this  
in connection with another chart, Doctor, but if you  
will look at page 48 of the chart following the arrest  
note and the resuscitation note, do you attach any  
significance to the fact that the nursing note for the  
period 7:00 p.m. to 3:00 a.m. August 17 to 18 appears  
not to have been completed until after the death of  
the child?

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A. Yes.

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Q. I am sorry, you do attach some

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significance to that?

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A. No, I don't. I notice that it  
has been completed after the death.

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Q. Does that suggest to you that  
there was anything of any particular significance in  
that period which called for immediate charting as it  
was happening?

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A. I don't think that when things  
happen at that speed anybody has time to chart that,  
but I believe that the nurses generally tend to write  
on pieces of notepaper and then --

12

Q. And do all the charting together?

13

A. I am not absolutely sure. You  
would have to ask --

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Q. We had better ask someone who  
does it?

16

A. Right.

17

Q. Okay.

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A. But I wouldn't attach any  
significance myself to that.

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Q. It is fair, is it, that not only  
was the course of these events rapid but they appear  
to have had a sudden onset?

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A. Yes.

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Q. And there appears to have been

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no prior warning that this child was at such imminent risk of death?

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A. In terms of --

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Q. Of the observable signs and behaviour of the child. The child had apparently been stable?

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A. Yes.

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Q. For two or three days and then suddenly went into this pattern of terminal events?

10

A. Yes.

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Q. Which is essentially I think what Dr. Olley said in his categorization report on page 50 the chart, isn't it? In very much shorter form the final sentence under "Procedure":

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"Sixteen hours after the procedure the child suddenly developed ventricular fibrillation and could not be resuscitated."

18

A. Yes.

19

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Q. There is no real question about the suddenness and the rapidity of those events.

21

A. Hm-mm.

22

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Q. Do you, Doctor, in considering this death, consider the onset, the nature and rapid course of the terminal events to be of any significance?







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A. Oh, they were significant because they implied the baby was dying.

4

Q. Yes, obviously, but did you attach any significance to them in considering why or what caused this baby to die?

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A. No.

7

8

Q. Were you satisfied that the baby's death and the time and manner of her death were completely consistent with her physical condition?

10

A. Yes, I was.

11

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Q. And once again as you told me forthrightly yesterday, I take it you can say no more than that her death and the time and manner of her death were consistent with her condition, with the condition of her heart and her anatomical deformation?

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A. I might be able to say that that would be the usual manner of death of this particular group of babies.

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Q. Once again may I ask you is that roster of symptoms and their pattern of onset and sequence equally consistent with digoxin intoxication?

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Q. Now, Dr. Rowe, by the end of September then two meetings had been held and six of the ward deaths that had occurred in July and August





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had been reviewed.

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How would you sum up the results of those two meetings? May I ask you a particular thing first? You have told me one of the purposes of the meeting and I take it an important purpose was to reassure the nurses that it wasn't their mismanagement of cases that was the cause of these deaths.

Did the meetings appear to succeed in conveying that message?

A. Well I hoped they did. I don't know whether they did because I didn't pre-test or pro-test their responses.

Q. There was none of that nasty word feedback later?

A. That is right.

Q. All right. No regurgitation? In the cardiac sense not in the other.

A. No.

Q. Other than that what did you perceive the results of the meetings to have been?

A. Well, I think that we all gathered the impression that this had been a useful forum as we proceeded and that there would be - there were a number of mutual aspects with both nursing and physicians that might properly be used to try and look





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at the problems we had to deal with in facing these seriously ill babies.

We did obviously have concerns about whether, when babies are very seriously ill, there should not be some way of having more detailed monitoring or more one-on-one type nursing than might be possible on the ward in its ordinary form.

So the question was raised at the end of the conference about the matter of having something in the way of an intensive care area, recognizing that you cannot have an intensive care unit on the floor because it is a very highly specialized area requiring different type of personnel, but believing that there might be some benefit to having an intermediate intensive care unit.

Again that is a word that could be defined in a number of different ways, but it is what I regard as intermediate between ward care of the ordinary regular type which was being provided and truly intensive care.

It seemed to me at that time and I think that the reaction that I received led me to believe that it would be worthwhile looking to that question, and it was suggested as the minutes record that we sit down and try and come to work out the needs that are







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necessary, that the nurses might feel necessary and the physicians might feel necessary to have that and to work out ways in which that might be accomplished. That was I think a major conclusion.

Q. Yes?

A. The other conclusions, and there may have been more discussed than are revealed there - I haven't obviously covered them all; the head nurses seemed to have more detailed information than I have - but I believe one of the things we said was that there should be a way in which the dosage schedule of drugs which are used in cardiac arrests should be made a little more obvious than just the handbook, and so the decision was made that the senior cardiac fellow, Dr. Jedeikin, and the nursing staff would work on that issue and work out something that was suitable from both points of view.

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We also thought that these seemed to have been productive in terms of patient care management. And so that there would be an advantage to continuing with such discussions from time to time. I believe there were some discussions about what was the best time for nursing, and apropos their problem of time and what might be suitable for the physicians. It wasn't decided at that meeting exactly what would be done, but it was decided that there would be another meeting and it would probably be held on the Monday, in one or other places of the Hospital depending upon what was resolved later.

Q. I am sorry, Doctor, have you finished?

A. I have finished.

Q. I think in light of what we know about what came later, would it be fair to say that the - perhaps the most significant of the conclusions that came out of this was the consensus that developed as to the desirability of something called an intermediate Intensive Care Unit?

A. Yes.

Q. Is that right?

A. Yes.

Q. You said you regarded it as





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something half way between normal ward care and the kind of care that is provided in an Intensive Care Unit. Unfortunately, Doctor, we laymen all have a rather different idea of what an Intensive Care Unit is. Can you help us just a little, what did you have in mind as constituting an intermediate Intensive Care Unit?

A. Well, we hadn't formulated exactly at that stage what it should be. I think perhaps at the beginning I was wondering if it might be possible to have some respiratory assists procedures, though I realized that we couldn't have full ventilation and respirator arrangement.

I was more of the opinion at that stage that what we needed was to have a capability of having small babies, who were suffering from very severe heart disease, be able to be monitored very much more closely than was feasible with a pretty stretched nursing staff on the floor. In no way were we making any suggestion that the nursing staff were not doing a superb job, and I think that needs emphasis. The issue was simply that the number of babies seemed to be, the number of sick babies seemed to be higher than we had encountered in the past. The number of younger babies seemed to be higher

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than we had encountered in the past. Therefore it seemed that it would be necessary to somehow or other increase the nurse-to-patient ratio to more than was possible under the routine staffing of the ward, even though under special conditions it was possible to adjust that.

So that this Intermediate Care Unit really had as its primary objective a means of having more nursing observation upon babies, and that would be possible through an increased number of nurses, because any Intensive Care or Monitoring, or whatever you want to call that unit would by definition demand more nurses per patient.

Q. I think I understand the concept now, Doctor, and recognize the desirability of such a unit. Is it fair to say that the existence of an intermediate ICU on or close to hand to the Cardiac Wards in July and August of 1980 might or might not have made a difference with respect to the children whose deaths had been reviewed at the September meetings?

A. Could I have that repeated please?

Q. Yes. Would the intermediate ICU have made any difference with respect to these





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children whose deaths were reviewed?

A. I think in many, probably not, in terms of outcome. It could conceivably, might have, changed the time of death, might have allowed a transfer to the Intensive Care Unit, or other measures might have been taken somewhat earlier.

Q. Doctor, haven't we been seeing a pattern where following a period of relative stability there has been a sudden onset and a very rapid course of terminal events?

A. That is true.

Q. Are you suggesting that those children might have already been in an intermediate ICU had one been available before the onset of those events?

A. Yes, I think that is probable. That would be our view with the formation of such a unit, that the high risk babies would be placed in that unit so they could be monitored very closely indeed.

Q. Doctor, is there any suggestion in any of the cases that we have reviewed so far that the problem was that the difficulties of these children had gone unnoticed? Was it not rather that events moved so quickly and so inexorably that intervention was impossible?





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A. Well, that is one explanation.

It is also possible in a situation where you don't have extremely close monitoring of the type I am talking about, that the events that are taking place that would be noticed under very close monitoring are not recognizable because they are not violent or very obvious things, they are minor things, I think that is experienced in many Intensive Care Units, that you pick up changes in the condition sometime before the baby starts to deteriorate. They are subtle changes but they may be picked up earlier, that's all. I am not saying that in every case we could have achieved prolongation of life, and that of course is one of the difficulties of moving rapidly on that suggestion.

Q. But lacking such a facility, it is also fair, isn't it, that patients who required closer observation in the judgment of the physician in charge, could have that closer observation ordered for them even on the ward, could they not? A doctor could order constant nursing care for a patient if he thought it was required?

A. Or the nurses themselves might make that decision.

Q. Of if he didn't think constant nursing care was required he could order shared care,







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could he not?

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A. That is true.

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Q. And as I understand it

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constant nursing care means that that child for whom

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that care is ordered has the exclusive attention of

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one nurse?

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A. Yes.

9

Q. A one on one relationship, is

it ont?

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A. Yes.

11

Q. And shared care, the nurse

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is responsible for two, and two only, children,

13

is that your understanding, Doctor?

14

A. Yes.

15

Q. Now, the patients whose

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deaths were reviewed at the two meetings in

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September, are you able to tell me whether any above

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normal level of nursing care had been ordered for

any of them?

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A. Well, I can't answer that

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question. I am not the responsible physician at

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the time and I think only those people can answer  
that.

22

Q. But such orders if made by

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the doctor will be on the chart, wouldn't they?

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A. Not necessarily.

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Q. Let me tell you, Doctor, I am prepared to leave the evidence at a later stage, and I can give you only what my information is from a review of the charts and the nursing assignments. It is my understanding that the only child for whom any enhanced level of care was ordered was Baby Monteith and for her shared care was ordered.

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Now, if those facts be correct, and as I say I am prepared to adduce evidence about it, if those facts be correct would it not suggest, Doctor, that the physicians in charge of the management of those children did not perceive their conditions to be such as to require an enhanced level of nursing care?

15

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A. I don't think that follows.

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Q. Are you suggesting to me that if a doctor thought closer observation by either constant nursing care or shared nursing care was necessary for a patient he would not order it?

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A. I think he would discuss it with the nursing group, either at resident level, Fellow level or staff level. It would depend upon the capability of that being done I would suspect.

If you want the detail on that, you





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would have to speak to the head nurses and the  
physicians are the responsible parties.

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My approach if I was on the ward would  
be to speak to the team leader or the head nurse and  
say I think this baby needs closer monitoring, if  
you can get more nursing that would be fine. If I  
thought it should go to ICU I would approach the  
ICU staff, but I might not necessarily write that on  
the chart.

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Q. Doctor, if you were not able  
to obtain the level of nursing care that you thought  
your patient required, what would you do?

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A. Well, we would try to get  
doubling up of nurses which they try to do, they  
try to do this. I think it depends - you have to  
realize that there was a shortage of nursing during  
that time and there was considerable difficulty in  
getting replacements for those that were on vacation,  
or were sick, and there was a lot - there were a lot  
of times when I understand doubling up of nurses  
was the case.

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We also didn't have the same capability  
of getting patients into the Intensive Care Unit,  
not because the intensivists wouldn't respond  
to discussions on that point but because the Intensive

*This has now  
become a  
fact!*







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2 Care area was very highly occupied during that  
3 particular period of time. The occupancy had  
4 substantially risen in the spring of 1980 and there  
5 was always difficulty in getting patients accepted  
6 because priorities have to be taken, and the  
7 intensivists would certainly not take anyone that  
8 we were a little worried about. So there were  
9 no answers of that sort that it interfered to  
10 some extent with the decision as to what would be  
done about a particular patient.

11 Q. Doctor, you have told me that  
12 the nurses too are able to make a decision to  
13 devote extra or particular care to one or another  
14 patient, they don't have to have that ordered for  
15 them in order to make that judgment.

16 You are familiar, are you, Doctor,  
17 with something called the NARVEL system?

18 A. Not in great detail, I know  
19 about the system. I am not a nursing individual  
20 so I don't follow all their detailed procedures,  
but I know it is an evaluation procedure.

21 Q. And it is an evaluation  
22 procedure is it not to determine the manpower of  
23 nursing required to provide care for a given  
24 population of patients with particular characteristics.  
25





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A. Yes.

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Q. And it is an assessment that  
is made from time to time how many bodies do we need  
to do this job for these people.

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A. It is a system I gather  
that is designed to do that.

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Q. And you are aware I take it,  
Doctor, without knowing any of the details of  
staffing and scheduling, that nurses from one ward  
in the hospital may be assigned to assist and help  
out on another ward when there is a particular  
demand?

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A. Well, I am not familiar with  
all the details of what the nursing service does,  
but I assume it is something like that, but I  
don't know for sure.

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Q. Are you aware whether the  
Hospital has a pool of nurses available to come in  
by the day as needed, referred to often in assignment  
books as per diem nurses, a sort of hospital over-  
load system?

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A. Yes.

Q. You are aware of that?

A. Yes.

Q. You told us of the impression





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3 is what you called it on Tuesday, the impression that  
4 you had in July and August of 1980 in which there  
5 was a serious shortage of nurses at that time especially  
6 at night, do I recall that evidence correctly?

7 A. Yes. I think you have to  
8 realize I am getting this feedback from other  
9 individuals. Again if you want to know specifics  
10 about times when those nurses, when it was perceived  
11 by the cardiologists that there was a shortage, or  
12 by the head nurses, you would have to ask them  
13 directly.

14 Q. But I did ask you on Tuesday,  
15 or Wednesday, whether you had any recollection in  
16 July and August of any information coming to you  
17 from the nursing staff, whether through a nursing  
18 specialist or anyone else, that they were short of  
19 nurses on the ward. As I recall your evidence you  
20 could not recall any such communication?

21 A. No.

22 Q. But your impression, and I  
23 think you said your firm impression was that there  
24 was a shortage of nurses on the Cardiac Wards at the  
25 end of the summer, and particularly at nights I think  
you said?

A. Yes.







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Q. And did you think that that  
might have had anything to do with the increased  
death rate that was experienced on the wards in  
those months?

A. I thought it might have some  
relationship.

Q. Dr. Rowe, did you make any  
effort to confirm the impression you had about the  
shortage of nurses at night?

A. I didn't examine that directly,  
no.

-----





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TORONTO, ONTARIO

Rowe, dr.ex.  
(Lamek)

S.C.

/BB/ko

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A. I didn't examine that directly,  
no.

Q. Did you ask anybody who might  
have been closer to the situation than you were  
whether there was a shortage of nurses at night on  
your wards?

A. I can't recall whether I did. I  
don't believe I went to the nursing administration or  
anything of that sort.

Q. Well, Doctor, I suggest to you  
that if you believed, rightly or wrongly, that there  
was a shortage of nurses on those cardiac wards at  
night which may have been contributing to the high  
on ward mortality rates that were being experienced,  
then why, by the end of July when five children had  
died, were you not pounding on the table for more  
nurses?

A. Well, I think I have told you that  
I wasn't absolutely sure that this was in relation to  
the deaths. We just wondered whether there might be  
the possibility that that could be the case.

Q. Well, with the greatest of respect,  
Doctor, and I mean no criticism at all, I suggest that  
you weren't even sure that there was the shortage of  
nurses about which you had an impression. Is that fair?

Why didn't  
he find  
out?





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A. We knew there were fewer nurses

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on the ward at night than the day. We weren't sure

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there was a shortage of nurses, I suppose, if you want

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to put it that way.

6

Q. Well, you used the word shortages,

7

as I recall it?

8

A. Yes.

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Q. Certainly there were fewer nurses

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on duty at night than during the day. But that's true  
in any ward in any hospital, is it not?

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A. Yes, it is. But we are dealing

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with a sick group of patients.

13

Q. Well, I understand. Well,

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perhaps we can get into that later with some nursing  
specialist, forgive me. I didn't mean to be

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argumentative with you, Doctor.

16

Now, the six children who were discussed

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at the two meetings in September had another feature

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in common, did they not? Each of them had been the

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object of a resuscitation attempt by the resuscitation  
team?

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A. Yes.

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Q. And, indeed, as I review the

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charts, in the 10 deaths which had occurred on the

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ward between July 1 and August 31, there had been

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seven Code 25s called, and those in the cases of  
Bilodeau, Taylor, Turner, Dawson, Monteith, Shrum  
and Velasquez, and all seven resuscitation attempts  
had failed, had they not?

A. Yes.

Q. Is that an observation that you  
made when you were looking over these cases for the  
September meetings, Doctor?

A. We certainly realized they hadn't  
been resuscitated.

Q. Did you have any concern there had  
been, to put it bluntly, a hundred percent failure rate  
with those attempts?

A. No, that didn't concern me. I  
mean, it concerned me that we weren't able to get the  
babies to survive, but it didn't concern me that the  
resuscitation attempts failed.

Q. You told us I think on Tuesday  
that there was now some information to suggest an 11  
percent success rate with resuscitation on cardiac  
wards and nowhere do you have that information?

A. Yes.

Q. Maybe 7 is too small a sample for  
the overall average percent, but we can work it out.

A. Yes, I think it is very possible.





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TORONTO, ONTARIO

Rowe, dr.ex.  
(Lamek)

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Q. Now, we know there was to be another meeting after the September 26th meeting, it was going to be on a Monday and Dr. Jedeikin was going to arrange it. For what purpose was there to be another meeting held, Doctor?

A. Well, I thought that there were a number of advantages that came out of the first two meetings that would suggest we should continue this dialogue, in addition to the other measures that we took to look at the deaths. So, I thought that that probably should be something at least for the present we should continue.

Q. When did you contemplate that next meeting might be held?

A. I think it was - I can't recall exactly when we had a prediction at that time, but I think it was to be arranged during the next month.

Q. Now, in fact, as far as I am aware, there was not another meeting, a mortality/morbidity conference until January, but you were away during the fall, were you not?

A. Yes, I was.

Q. Late fall, early winter, and you were very far away, as I understand it?

A. I was.

What was  
they?





Rowe, dr.ex.  
(Lamek)

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Q. Back in New Zealand lecturing,

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I think?

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A. I beg your pardon?

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Q. Were you lecturing back in New

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Zealand?

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A. I was lecturing in Australia and

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New Zealand, yes.

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Q. And when did you leave, Doctor,

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and when did you come back, approximately?

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A. I haven't got the exact dates -

I think I have got the exact dates somewhere here.

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Q. Roughly is what I am after.

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A. Well, roughly, it was from the

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middle of October to the first week in December.

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Q. Now, Doctor, from the middle of

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October then, in your absence, it appears that four

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children died on the ward: McKeil on October 15,

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Adamo on October 19 and Volk on October 23. And I

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take it from the rough times you have given me, you

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A. Yes.

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Q. And one child had died in November,

that is to say, Matthew Lutes on November 17?

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A. Yes.

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Q. And there was not another on ward

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(Lamek)

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death that I am aware of until December 9, by which  
time I take it you were back in town?

A. I was back by December 9, yes.

Q. And during the month of December,  
from and after the 9th, there were five on ward deaths,  
were there not?

A. Yes.

Q. That of Onofre on December 9,  
MacDonald on December 13, Gosselin on December 18,  
Lombardo on December 23 and Belanger on December 28?

A. 24?

Q. I beg your pardon?

A. Was it the 24th?

Q. I thought it to be the 28th,  
Doctor, but we can confirm that.

I take it that upon your return you were  
made aware, or you learned of the deaths that had  
occurred on the ward in your absence?

A. Yes.

Q. Now, let's go back then to the end  
of December. At that time, since your departure,  
there had been an additional nine children die on the  
ward; five of them in December. Did you observe, or  
was it pointed out to you, that six of those nine  
deaths and, indeed, four of the five that occurred in





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December, had occurred in the early hours of the  
morning?

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A. Yes.

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Q. Is that something you observed or something that was brought to your attention?

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A. That would have been at the daily discussions.

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Q. Now, as December wore on, from the time of your return and the number of deaths increased, what was your reaction to those incidents, what did you think?

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A. Well, I was becoming concerned over the numbers in a large way at that stage.

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Q. When you say in a large way, could you try to tell me just what it was you were worrying about at that point?

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A. Well, I was concerned about the number of deaths and the fact that although we still appreciated the severity of the disease in all these patients, that it was an impetus to review the entire group in considerable depth to see if there was any conclusion we could reach about the numbers, the high numbers.

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Q. Were you, during the month of December, beginning to question the conclusions or





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opinions that you had formed in September as to the cause of the deaths?

A. No. I think that we had perhaps, at least my reflection on that on return was that the numbers had reduced somewhat, and then as December went on those numbers seemed to be rising again and on a day by day basis that we examined this issue, it seemed to me a reasonable matter that we should begin to look in greater depth at the specifics of the more recent deaths and then add those to the specifics of the earlier deaths, try and reach some conclusions about whether management issues should be changed in any way.

Q. All right. Now, were other staff cardiologists or cardiac fellows expressing concerns to you, or expressing them to your knowledge about this same problem?

A. Well, you know, I don't recall specifically people saying to me, look here, Dr. Rowe, we've got far too many deaths occurring on this ward and so on, but obviously at the interchange we have on a daily basis at these conferences, people were concerned that we were having a large number of deaths.

But I think there was no doubt that everybody appreciated we had a large number of very







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sick infants to deal with and I think that there wasn't, to my knowledge, a major concern that there was mismanagement or anything that could be accounted for this, other than the severity of the defects.

Q. All right. To your knowledge, were the nurses concerned about the ongoing deaths on the ward?

A. I am not sure at that point because I wasn't on the floor at that time and I would rely for that sort of information from the cardiologists who were. I didn't specifically approach the head nurses, to my recollection, and say to them are you concerned about this.

Q. Was it your information that they were concerned?

A. That they were?

Q. That they were concerned?

A. I am not sure whether they were concerned. I imagine they were.

Q. It would be pretty surprising if they were not?

A. If they were not, yes.

Q. Well, we know that the Head of Cardiovascular Surgery was concerned, Dr. George Trusler?





Rowe, dr.ex.  
(Lamek)

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A. Yes.

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Q. Because he expressed his concern  
to you, did he not?

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A. He did.

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Q. Doctor, I am showing to you what  
appears to be a copy of a letter from Dr. Trusler to  
you dated December 15th, 1980. This is a two page  
letter and attached to it is a copy of a two page  
letter apparently from yourself to Dr. Trusler dated  
December 29th, 1980. Do you recognize those, please?

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A. Yes, I do.

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MR. LAMEK: May that exchange of  
correspondence be the next exhibit, Mr. Commissioner?

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THE COMMISSIONER: Exhibit 64.

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--- EXHIBIT NO. 64: Letter from Trusler to Rowe  
dated December 15, 1980,  
and letter from Rowe to  
Trusler dated December 29,  
1980.

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MR. LAMEK: Q. Doctor, I am obliged  
to ask you the very first question about this letter,  
why it was written at all? Is this the normal way in  
which you and Dr. Trusler communicate within the  
hospital?

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A. We usually communicate verbally  
but we also send letters or memoranda to one another  
if we want to provide details of a specific issue.

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Rowe, dr.ex.  
(Lamek)

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Q. I can understand certainly talking to each other and I can understand memoranda. But do you recall receiving a letter before Dr. Trusler?

A. I think I have, yes.

Q. Do you recall having written him a letter before?

A. Oh, yes.

Q. Rather than a memorandum?

A. Oh, yes.

Q. All right. On what sort of occasion?

A. Oh, I have written to him I think on matters about conferences or matters that I don't feel should be necessarily part of the hospital record that relate to working relationships between cardiology and cardiac surgery and so on.

Q. And was that your explanation for writing a letter to Dr. Trusler in response to his, that you did not think this should be part of the hospital record?

A. No, my letter demonstrates that it can be part of the hospital record because I have a distribution list.

Q. Yes.







Rowe, dr.ex.  
(Lamek)

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A. It can't go onto a patient's  
chart because it is not referring to a specific  
patient.

Q. Yes.

A. But the distribution list is to a  
wide number of people who are connected with the  
hospital.

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Q. Very well, Doctor.

In Dr. Trusler's letter to you he starts:

"As I mentioned to you the other day"

which I take it with piercing insight into the obvious there had been an earlier discussion between the two of you about some of the matters raised in this letter?

A. I believe there must have been.

Q. Do you have any recollection of the discussion?

A. No.

Q. I suppose it is a good thing he wrote you the letter?

A. Probably that is why he wrote it to me.

Q. All right.

As well as recalling that he mentioned to you earlier he says bluntly:

"I am concerned by our relatively high mortality. I think that it is higher than it has been in previous years. Much of this may be related to increased complexity of operation

He was v.  
concerned but  
he didn't even  
remember that  
Trusler dis-  
cussed this  
problem w. him





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Q And he goes on, sharpening  
his focus a little:

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"In particular, I am a little  
concerned by the number of deaths  
that occur back on the ward some  
time after operation. That is, after  
they have left the intensive care  
unit, and at a time when we would  
assume they are out of danger."

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I pause there for just a moment.

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A Yes.

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Q So the fact that a child has

apparently survived surgery, gone to the ICU, has  
been discharged from the ICU, spent a number of days  
back on the ward and then dies, he is still nonethe-  
less for statistical purposes and perhaps others a  
surgical death?

A Yes.

Q Was it your understanding

from this letter that Trusler was concerned that the  
surgical deaths were including children who, after







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surgery, seemed to be doing well, had been returned to the ward and died there? Was that his concern as you understood it?

A. He says that he is concerned by the number of deaths that occurred back on the ward some time after operation. That is what I take from that.

Q. All right. He says:

"It may be that we are sending them back too soon and I know that many factors are involved, but I might list a few of the cases just to show you the size of the problem. These are children who died many days after their operation and in most cases on the ward, I believe."

And the ones that he lists, the seven that he lists, Doctor, the only one we have come to at this stage in the review that you and I are doing now is that of Velasquez?

A. Yes.

Q. He lists seven and expresses his concern and says in effect if there is anything we can do let's get together and see what the problem is and see if we can resolve it.





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Now Doctor, on receipt of Dr. Trusler's  
letter what did you do?

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A. Well, it was my recollection  
that we had arrived at this point almost in parallel  
because I believe that we already were starting to  
look at the population and gather the information  
together, but I don't know for sure at what date we  
started doing that in December, but it was some time  
in December.

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Q. At that stage were you  
reviewing or were you about to review charts of recent  
deaths or had you instructed someone else to conduct  
such a review?

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A. Yes. Dr. Jedeikin, the  
senior Cardiac Fellow and myself had met on this  
point and had decided on an approach to the problem  
which I further outlined I think in this letter.

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Q. You replied to Dr. Trusler's  
letter on December 29th, 1980. There having been  
the intervention of Christmas and so on was there  
any other reason for there being two weeks elapsed  
between Dr. Trusler's letter and yours?

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A. He might have been away skiing.

MR. LAMEK: A nice thing to be.

I want to get into that, but before

Why was T's  
absence delay  
R's response?





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I do, Mr. Commissioner, I wonder if this would be a sensible time to take a short break?

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THE COMMISSIONER: Yes. We will take 15 minutes.

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MR. LAMEK: Thank you.

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--- Short recess

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--- On resuming:

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THE COMMISSIONER: Mr. Lamek?

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MR. LAMEK: Q. Dr. Rowe, if we could come to your letter of December 29th written in response to Dr. Trusler's letter - you have a copy of your reply in front of you there?

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A. Yes.

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Q. If I may say so there is a rueful quality, is there not, about the second paragraph, the second sentence of your letter:

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"We could I think without much trouble amplify the list of seven patients you gave us ...".

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A. Yes.  
Q. Including two within the week preceding your letter.

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You then go on to refer to the mortality and morbidity rounds that you had held, the two conferences in September, and it is your intention





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they should continue and you have told us why you  
had that intention.

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Can I just go back a moment now,  
Doctor?

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You said that upon your return from  
Australia and New Zealand at the end of the first  
week in December you learned of the further deaths  
that had occurred.

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You had also told us that it had  
been your expectation that a further mortality and  
morbidity conference was to be held in October,  
perhaps. When you came back you found there had not  
been a meeting since the one in September and there  
had been no conference at all during your departure.

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What was your response to that piece  
of intelligence?

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A. I was not particularly happy  
to hear that because that was a problem of communi-  
cation of some sort I believe.

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Q. Yes.

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A. It was known I think by  
Dr. Jedeikin that he had that responsibility put to  
him but for one reason or another he was unable to  
accomplish it.

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Q. You go on:

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"For the most part those patients  
discussed have been non-surgical  
patients ... "

and had it been your intention to convene a meeting  
involving surgeons as well at which postoperative  
deaths should be reviewed?

A. During the course of the  
previous seven months?

Q. Yes.

A. No. The surgical patients  
are reviewed separately. I mean we know when a  
patient who is a surgical patient dies, and we look  
at it ourselves, but they are reviewed by the  
surgeons separately within their own division and  
department, so that we feel pretty confident that if  
there is some issue that concerns them particularly  
about the surgery that they would come to us about it.

Q. And you go on to refer to a  
couple of the benefits or useful matters that had  
come out of the two meetings in September, the question  
of the nice large type card of dosages on the arrest  
tray on the resuscitation cart, and the "perceived  
need of an immediate intensive care unit on 4A/B".

I am interested in the next sentence:

"It is my feeling that such a unit





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"should be seriously considered, - particularly since most of the patients we are talking about are small infants at relatively high risk for respiratory arrests and who probably need a much higher nurse-patient ratio than is currently provided at nights on that ward."

Now you have told us something about that already, but of course I am interested in words like "it is my feeling that it should be considered", "they probably need a much higher nurse-patient ratio", and so on.

Doctor, I am not in any way being pejorative or critical about this. Was that a matter of impression of yours or experience or was there some data upon which that view as to the relatively high risk of infants for respiratory arrests was based?

A. No, I think that I would have been meaning there that the small infant, the smaller infant is more likely to have rapid deterioration than the older child.

Q. Is that particularly true from





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your experience or is it your impression that is particularly true --

A. Yes.

Q. At nighttime?

A. Well, I don't know that it is particularly true at night but I think I was of the impression that it would be more likely to occur at night because of the fact that this is a high risk group where the density of nurses decreases at night.

Q. All right. And you go on:

"Whether this should be officially tied in with the ICU proper and have staff attachment from that ward is a matter for further discussion but I think that the provision of such a small unit might offer a solution to some of these problems and that its formation should be seriously considered at this stage."

As of the date you wrote this letter to Dr. Trusler, late in December of 1980, were you satisfied that the problems had been defined?

A. The problems of the ward or the problems --

Q. The problems of the ongoing







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deaths and the deaths that Dr. Trusler was particularly concerned about in postoperative patients. Had you really at the end of December having now returned from your trip abroad and finding ongoing numbers of deaths on the ward, were you really satisfied that the problems had been defined sufficiently for you to know what the possible solutions were?

A. I don't think we could be sure of all the reasons why that might have been the case. We didn't have the sort of detailed statistics on this at all. And that is really how we have to work on a day to day basis, that we have to look back over a short period and see what went on and see what we think might be reasonable to look at further and to try and evaluate that together.

Q. And you go on to refer to some other possible causative matters, the early transfer of patients from the ICU, and you have already referred to that in your evidence, Doctor, pressure for space there and so on, and can you help me at the bottom of that page and the top of the next one:

"We have had examples amongst these deaths of patients in whom in the





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"intensive care unit the cardiologists  
were very concerned about the  
absence of a murmur and the very low  
PO2 levels."

Now I merely ask you to explain,  
please, the significance of the absence of a murmur  
and low PO2 levels. What is involved there?

A. That statement concerns babies  
who had a palliative operation to increase the  
pulmonary blood flow - that is they either had  
severe pulmonary stenosis of pulmonaria atresia and  
were having the Blalock Taussig anastomosis or some  
such type of shunt --

Q. Shunt?

A. -- shunt operation performed,  
and the judgment of whether such operation has had  
a good effect from that palliation is based upon the  
development of a murmur that is produced by the shunt,  
a loud noise that sounds like a churning of a  
separator or something of that sort, and produces  
a significant new physical sign so that a doctor  
listening with a stethoscope can tell that that shunt  
has been performed.

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It is in effect an artifical ductus arteriosis.

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Q. You hear the blood passing

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through?

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A. You hear the blood passing

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through this channel and it produces a murmur that

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is described as a continuous murmur, it is a very

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noisy noise.

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The second feature is the change in

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the amount of oxygen that can be measured in the

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blood of the artery of the individual, in the

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systemic circulation. By that we mean that in crude

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terms the baby is pink, or is pinker than he was

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before the shunt. He may have been very blue before

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the shunt but becomes at least mauve or somewhat

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more in that direction.

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So, PO2 is the term for the partial

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pressure of oxygen in blood and a low arterial PO2

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would be a more precise way of judging the effect of

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the shunt than just looking at the baby.

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Q. As I understand your suggestion

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that  
/you are raising in the paragraph, is perhaps you

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surgeons should be thinking about going back in and

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making sure the shunt is working, we are not hearing

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the murmurs and we are recording very low PO2 levels,

is that the message, is that what is coming out?







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A. Yes, I think obviously that might be construed by the surgeon as a little overstatement of the case. The point was to draw attention to the possibility that there might be reintervention in a borderline situation earlier than perhaps we had been doing.

Q. And the other thing I confess I do not understand, could you tell us briefly what it is you are referring to in the next paragraph phrenic-nerve palsy?

A. During the course of operations, particularly of those that are involved in providing a shunt procedure, but also in others, there may be injury introduced to the phrenic-nerve which supplies the diaphragm. That nerve, if it is injured it will become paralyzed, the muscle will become paralyzed, I am sorry, not the nerve, the muscle of the diaphragm becomes paralyzed and that can seriously interfere with the function of breathing, particularly in a small baby. It is not too much of an insult for an older individual, but for a small baby it can be quite critical. So that some babies who develop that complication at operation can have tremendous amount of respiratory difficulty and have to be ventilated for periods for as long sometimes as







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several weeks.

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Q. Is it the diaphragm not

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moving that restricts the ability of the lungs to

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expand?

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A. Yes, the diaphragm moves in

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a paradoxical fashion. On one side where it is

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paralyzed it goes up when the diaphragm should go

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down.

Q. I see.

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A. So it gets like that, and

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it really interferes rather seriously, particularly

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in small babies with their ability to exchange air.

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Q. All right. So if I can

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summarize it fairly, you acknowledge the concern,

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and you say these are things that we have been

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talking about, and I think there are a couple of

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other things that maybe you should be concerned

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about with your people, and you want to talk about

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that, and maybe you should all have a meeting

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together and discuss this thing. Is that essentially

the message that comes out of this?

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A. That is.

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Q. It was proposed that the

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meeting be held early in the New Year. There is

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an interesting list of persons to be present, yourself,

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Dr. Trusler, the two Head Nurses, the Area Nursing  
Co-Ordinator and the Administrative Ward Chief for  
4A/B. Why that selection of people?

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A. Why did I select those  
people?

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Q. Yes.

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A. Well, I thought that any  
decision about these matters would have to and  
properly should include nursing personnel, and  
obviously the Head Nurses of the Ward would be  
appropriate. We recognize that in inviting the  
Area Nursing Co-Ordinator she might want to have  
other people, and indeed that proved to be so, and  
we obviously wanted the surgeons to be both there.

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I think in further discussion about  
this we also introduced an obviously important  
individual for such a conference, somebody from the  
Intensive Care Unit who would have to give his  
opinion on whether this was a valid objective, or  
whether there were points that couldn't be managed  
by it and we would have to find some other solution.

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THE COMMISSIONER: I missed out,  
who is Dr. Trusler?

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THE WITNESS: Dr. Trusler is the  
Head of the Cardiovascular Surgery Division of the





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Hospital.

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THE COMMISSIONER: I know there is  
a great deal of co-operation, is there any chain  
of command between you and Dr. Trusler?

6

7

THE WITNESS: No. He is in an  
entirely separate department of the Hospital.

8

9

MR. LAMEK: Q. He reports to the  
Department of Surgery?

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11

12

A. He reports to the Department  
of Surgery.

13

14

Q. And you report to the Department  
of Pediatrics?

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16

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21

22

A. And I report to the Medical  
Department of Pediatrics.

23

24

25

Q. Before I get to that meeting,  
Doctor, I think there is one thing that I think I  
should properly go back to and that is the question,  
forgive me for taking it out of order and disrupting  
the chain of thought, the question of resuscitation,  
We mentioned that briefly just before the break and  
I pointed out to you that the ten ward deaths that  
occurred, that there had been resuscitation attempts  
for seven and all seven had been unsuccessful.

I take it there were during the 9 month  
period which concerns us, some successful







1

2

resuscitation attempts?

3

A. Yes, there were.

4

Q. And you have told us of the -

5

your information as to the ongoing success ratio of the

6

Resuscitation Team on the Cardiac Ward and I think you

7

said it is about 11 per cent.

8

A. No, that figure comes from

9

data that is obtained during the period under

10

discussion from March of 1980 to - at least from

11

July 1980 to March 1981.

12

Q. So in that year, which

13

includes the period with which we are concerned ,

14

of all resuscitation attempts undertaken there was

an 11 per cent success ratio?

15

A. Yes.

16

Q. And some of those obviously

fell within the period with which we are concerned?

17

A. Yes, and that ratio is

18

approximately the ratio that is found in success

19

in resuscitation in most experiences in hospitals.

20

Q. Good, and I think it is as

21

well that that is cleared up, I didn't want to leave

22

the wrong impression about that.

23

A. Thank you.

24

Q. Now, sir, can we go back to the

25





1  
2 point of the ongoing narrative here?

3 The meeting was to be arranged in  
4 the early New Year. I have already explored with  
5 you to some extent the nature of the concern that  
6 you were now feeling about this ongoing increase in the  
7 number of ward mortalities.

8 You were now aware I take it of some  
9 21 or so deaths that had occurred between July 1,  
10 1980 and December 29, 1980 on the wards. Although  
11 you may not have received the number, I take it from  
12 what you said you were aware that a substantial  
13 proportion of those had occurred in the early hours  
14 of the morning, and indeed by my count, Doctor, I  
15 total it to be some 14 out of the 21 occurred  
16 between 1:00 a.m. and 5:00 a.m.?

17 A. Yes.

18 Q. Without knowing perhaps the  
19 precise numbers you were aware of that pattern, were  
20 you?

21 A. Yes.

22 Q. Now, was that pattern of  
23 distribution of the deaths around the clock, would  
24 it in itself cause or add to your concerns?

25 A. I think I would agree it must  
have, because we kept on commenting about this in

They recognized the pattern. They were concerned about it but their canvassing of the possible reasons for it produced only an impression that the wards were understaffed with nurses at night — an impression which was unsupported by any allegations to that effect by the nursing staff and which they did absolutely nothing to check!

"A proportion"? 14 out of 21 die between 1 a.m. - 5 a.m.?



1  
2 relation to the nursing cover at night. I don't  
3 recall that we sat down and said, my goodness, there  
4 is this many between 1 o'clock and 3 o'clock, I  
5 don't think we ever did anything like that. But on  
6 the day to day basis it was apparent that many of  
7 them were at night and that I think led into the  
8 question of possible reasons why that might be.

9 Q. But you had not yet, as I  
10 understand you, you had not yet made any association  
11 or attempted to discern any association between  
12 nighttime deaths and the presence of particular people,  
13 particular nursing units, or other people on the ward,  
14 residents on duty, that sort of thing?

15 A. No, because I think we all  
16 recognized that you are going to have a proportion  
17 of patients who die at night. Although we didn't  
18 have figures on that basis from the Hospital and  
19 it remained for others to get those figures with their  
20 computers and other rather extensive efforts to  
21 put the times together for a large number of deaths,  
22 nevertheless we thought that one should expect a  
23 considerable proportion of patients to die at night.

24 Q. Doctor, it may not be the  
25 kind of exercise that one can readily find the time  
to perform in the middle of a busy clinical practice,







G9

1  
2 but in your consideration of the increased mortalities  
3 ward mortalities that you were experiencing, would  
4 it not have been helpful for you to know of the  
5 clustering that appeared to be occurring between  
6 1 o'clock and 5 o'clock in the morning?

7 A. I suppose it might have been  
8 but I am not sure.

9 Q. Well, would that not have  
10 produced a more refined focus than merely children  
11 are dying at night, which as I understand it was  
12 your perception?

13 A. Yes.

14 Q. After all, one can assume,  
15 I suggest to you, that since there are 12 hours of  
16 day and 12 hours of night you expect a roughly  
17 equal number to be dying in each 12 hour block?

18 A. I think that is not unfair.

19 Q. But if you found in fact a  
20 very substantial percentage was dying in a four-hour  
21 time period that might, might it not, put a rather  
22 different complexion upon the analysis?

23 A. Well, I think that would  
24 depend on the numbers involved and you might need  
25 a larger number to reach that conclusion than the  
number of deaths that we are talking about here,







Rowe, dr.ex.  
(Lamek)

1

2

which is 20.

3

Q. Doctor, in relative terms

4

we are talking about three years worth of ward

5

deaths, are we not, 20?

6

A. Yes.

7

Q. Your average death rate ---

8

A. Yes, but the ---

9

Q. --- over nine months?

10

A. The total number I am talking

about in relation to that sort of observation.

11

Q. Yes.

12

A. Is only 20.

13

Q. I am suggesting to you,

14

Doctor, that was a very substantial number, was it not?

15

16

A. It is a substantial number of

17

deaths but I question whether it is a large enough

18

number to make detailed analysis of the time, the

timing of death.

19

Q. Is it not a piece of information

20

which might reasonably have caused you to make

21

enquiries as to why - as to whether indeed there was

22

any significance to that clustering, and if so what

23

might be causing it?

24

A. I think today you might take

25





1  
2 that position but at the time we did not.

3 Q. You were still nevertheless  
4 at the end of December concerned to know why these  
5 high numbers of deaths were continuing, were you  
6 not?

7 A. Would you repeat that, please?

8 Q. Yes. You were still concerned  
9 at the end of December to know why the deaths were  
10 ongoing?

11 A. Yes.

12 Q. And you have told me that  
13 your concern then was perhaps deeper or sharper  
14 than it had been at the beginning of September?

15 A. Yes.

16 Q. I take it from what you said  
17 earlier at least the possibility of mismanagement  
18 of the patients had occurred to you as a possible  
19 explanation?

20 A. A very distant possibility.

21 Q. Whether that be mismanagement  
22 by physicians or by nurses. Why was that so distant  
23 a possibility, Doctor?

24 A. Because we had reviewed as we  
25 went through the nature of the malformations, the  
nature of each death and we hadn't in my view come

G11

Incredible! Rowe is the head of the Division. ~~He~~ He returns from a 6-7 weeks absence to find:

- (a) large numbers of on-wound deaths are still occurring.
- (b) many of the deaths are occurring at night
- (c) the Sr. Cardiac Fellow, who was to have arranged follow-up m.m. confs in Rowe's absence has done nothing and Rowe can't even remember if any cardiologist in his Division ~~was~~ spoke to him about possible explanations for the situation!





1  
2 up with any obvious factor that would suggest mis-  
3 management.

4 Q. I am certainly not suggesting  
5 that you should at that stage turn your mind to the  
6 possibility of foul play. Did you not entertain  
7 the possibility of some unintentional mismanagement  
8 as a possible explanation?

9 A. We wanted to look at that  
10 question, but we didn't really think that that  
11 was the case, at least as a result of our preliminary  
12 day to day discussions that had not really emerged.

13 Q. Had you in the period from  
14 the date of your return - I think you said the end  
15 of the first week in December to the end of December,  
16 in that three weeks, had you had any discussions with  
17 any of the staff cardiologists about the possible  
18 explanation for the continuing on ward deaths?

19 A. I think we probably did but  
20 I don't recall, I didn't have a specific meeting  
21 addressing the topic as such, but undoubtedly there  
22 would have been discussions about that because when  
23 I came back I was informed of it.  
24  
25







C.

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TORONTO, ONTARIO

Rowe, dr.ex.  
(Lamek)

H/BB/ko

- 1
- 2 Q. Do you recall any discussion with
- 3 any of the cardiac fellows about possible explanation
- 4 for the ongoing high mortality on ward?
- 5 A. I don't recall.
- 6 Q. Or with any member of the nursing
- 7 department, nursing specialist, head nurse, director,
- 8 assistant director, floor nurse?
- 9 A. It doesn't strike me as a major
- 10 interview or anything of that sort.
- 11 Q. Do you have any recollection of
- 12 any discussion, conversation, exchange with anyone
- 13 else in the hospital other than Dr. Trusler and the
- 14 exchange of correspondence that we have seen, as to
- 15 the possible explanation for the ongoing situation
- 16 as you found it in December?
- 17 A. I don't remember the discussions
- 18 that I might have had with other people. Certainly no
- 19 specific formal meetings were held. But I must have
- 20 spoken to Dr. Edmonds.
- 21 Q. Doctor?
- 22 A. Edmonds.
- 23 Q. Is he the intensivist?
- 24 A. He is the intensivist, yes.
- 25 Q. Yes. But you don't recall?
- A. No, I don't recall exactly the





1  
2 circumstances that I would have done that, but I must  
3 have spoken to him because I invited him to the  
4 meeting and I must have talked about the background  
5 of the reasons for the meeting.

6 Q. Yes. Did you continue to have  
7 the impression as at the end of December that the  
8 severity of illness of your patient population was an  
9 explanation for the continuing high level of on ward  
10 ~~activity?~~ <sup>mortality</sup>

11 A. Yes, I did.

12 Q. And did you continue to have the  
13 impression as at the end of December that there was,  
14 what you have earlier said, a shortage of nursing on  
15 night duty in the cardiac wards and that that might  
16 be part of the explanation for the ongoing high  
17 mortality?

18 A. I think all of these factors  
19 entered into my thoughts at that time.

20 Q. You continued to hold those views?

21 A. Yes.

22 Q. Now, as I understood you on  
23 Tuesday, Doctor, talking about those impressions that  
24 you had at that time, you referred to clusters of  
25 particular kinds of deformities, seriously ill patients,  
that sort of thing, and I think in the context of





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possibly regarding the deaths in July and August as a manifestation of a cluster of seriously ill patients resulting almost inevitably in a number of deaths. I accept that such clusters can occur and they are recorded in the literature.

Do I correctly characterize what you are advancing as a possible explanation the impression that we had particularly seriously ill patients who were in a sense clustering, there was an unhappy concatenation of these poor patients resulting in higher mortality?

A. Yes.

Q. Did you continue to be of that view, that what you were seeing as a clustering of seriously ill patients as at the end of December?

A. I thought that was still a possibility, a good possibility.

Q. If there were a clustering of seriously ill patients, Doctor, would that explain why deaths were occurring on the ward because, as you have told me, the ward is not the place where children usually die? It might explain a high number of deaths from those of whom you have admitted, would clustering of seriously ill patients explain a large number of on ward deaths?

A. It could.







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Q. It could. Would it be more likely to produce a higher number of children who died either in the operating room or in the ICU?

A. I think that's a fair statement, assuming that a good number of those seriously ill babies would have conditions that are amenable to surgical intervention, yes. But some of them would not.

Q. Would the cluster idea explain the, what I will call the overlaid cluster of a large percentage of deaths occurring in the middle of the night?

A. It might if they were severely ill babies, yes. I think that is definitely one explanation that could be advanced.

Q. The suggestion is that severely ill babies tend to die at night?

A. I think that would be more likely if they were not as closely monitored at night as during the day, they would be more subject to this. They would be a higher risk I think.

Q. Doctor, do you have any reason to question or dispute the information that was produced here on Tuesday morning as to the number of deaths that have occurred on those wards in the middle of the night







H 5 1  
2 over a three year period?

3 As I recall it, in the 18 months  
4 immediately preceding the nine month period in which  
5 we are interested, there had been one death between  
6 the hours of 1:00 and 5:00 and in the succeeding 18  
7 month period there had been one death between the  
8 hours of 1:00 and 5:00. Now, it may be that that time  
9 span was not long enough. Will you agree with me that  
10 on the basis of that information at least, it does not  
11 suggest that children on the cardiac ward tend to die  
12 in the middle of the night?

13 A. On the basis of that information  
14 presented, yes.

15 Q. Do you have other information  
16 which would lead you to challenge the validity of  
17 that?

18 A. I don't have that information, but  
19 one would like to see more extensive analysis.

20 Q. Yes. Now, if indeed as from the  
21 data that we do have it appears that there is a degree  
22 of unusualness about a <sup>cluster</sup> question of deaths in the middle  
23 of the night, then that would constitute, wouldn't it,  
24 two clusters coinciding on your impression of this  
25 case: a cluster of seriously ill patients and a cluster  
of the deaths of those patients on the ward at a





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particular time of the night?

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A. Yes.

4

Q. And will you agree with me,

5

Doctor, that would be a rather unusual situation to  
encounter, would it not, the coincidence of clusters?

6

7

A. I don't think that the two are

8

necessarily separate. I think one might depend on

9

the other, such as the severity of the illness and

10

that might be the reason why you got more deaths  
occurring.

11

Q. Yes.

12

A. And the severity of the illness

13

might indicate that the monitoring situation might

14

explain that more deaths occur at night.

15

Q. Well, unhappily we don't have

16

statistics to establish that more deaths occur at

17

night or even that very many deaths occur at night,

18

but perhaps those statistics might be available,

Doctor.

19

A. Yes.

20

Q. Can we come to the meeting of

21

January 12th, 1981? Did you chair that meeting?

22

A. Yes, I did.

23

Q. And did you prepare minutes of the

24

meeting?

25







ANGUS, STONEHOUSE & CO. LTD.  
TORONTO, ONTARIO

Rowe, dr.ex.  
(Lamek)

H 7

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A. I did.

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A. The last page of this document does not belong to the minutes.

11

12

Q. But the rest of the minutes are as you prepared them?

13

A. Are there, yes.

14

15

Q. Thank you. Then we will detach the last page and ask that the minutes as identified by Dr. Rowe be the next exhibit, please?

16

THE COMMISSIONER: 65.

17

--- EXHIBIT NO. 65: Minutes of meeting of  
January 12th, 1981.

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MR. LAMEK: Mr. Commissioner, perhaps I should make it clear. The last page which has been detached but which may have been distributed with the real minutes to Counsel and others is a list of names alphabetically arranged bearing date in the lower right-hand corner, April 15, 1982. That is not part of the exhibit and was not part of the minutes of the







ANGUS, STONEHOUSE & CO. LTD.  
TORONTO, ONTARIO

Rowe, dr.ex.  
(Lamek)

H 8

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2

meeting prepared by Dr. Rowe, as I understand it.

3

4

Q. Doctor, the minutes describe this conference as a luncheon conference. Do you recall how long it lasted?

5

6

A. No, I don't recall how long it lasted but I can guarantee you that it was more than one hour.

7

8

Q. Was it more than three hours?

9

10

A. I don't know. I don't think it would possibly go on that long. It would be a couple of hours in my estimate.

11

12

Q. Right. Indeed, it was truly a lunch conference, it didn't take up the afternoon as well, is your recollection?

13

14

A. Correct.

15

Q. Okay.

16

17

A. Well, that's a longer lunch conference than we usually have.

18

19

Q. Well, I know, but lawyers think in more <sup>a</sup>expensive terms, Doctor.

20

Were individual deaths actually discussed at this meeting?

21

22

23

A. No, individual deaths were not discussed at this meeting because we had prepared the data prior to the meeting.

24

25

The purpose of the mtg wasn't to  
review deaths anyway. Rowe saw  
it as a mtg of those who could  
advance the proposal for an  
intermediate icu.



Rowe, dr.ex.  
(Lamek)

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H Q. Certainly as I read the minutes, Doctor, I had the impression that they were telling me that results of a prior review of deaths were prepared and presented to the meeting as a taking off point for the discussion of certain suggestions. Is that a fair characterization?

A. That's a good characterization.

Q. If there then is what occurred, I take it that in advance of this meeting you, I assume, <sup>with</sup> ~~for~~ the assistance of other staff cardiologists and fellows, reviewed or discussed and categorized the deaths and then presented numbers by category to the meeting?

A. Yes.

Q. Do you recall whether at the meeting there was any question raised with respect to any one of the deaths?

A. I do not believe there was any question.

Q. Okay, Dr. Trusler didn't say, well, come on, what about old so and so, we shipped him back in fine condition, none of that stuff at this meeting?

A. No.

Q. All right. Were questions invited about the review results that you put before the meeting?





Rowe, dr.ex.  
(Lamek)

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A. I don't recall that I specifically  
*questions*  
invited requests, but knowing the population that I  
was addressing, it is unlikely that if I hadn't  
invited they would have refrained if they had felt  
the necessity.

Q. Do you recall whether anyone did  
ask questions or make comments about the analysis of  
deaths that was presented to the meeting?

A. No, I don't recall that there was  
any major dissent.

Q. All right, then I will come back  
later to the manner of characterization. Perhaps we  
can look at the minutes. You have told me that you  
prepared these. That, Doctor, makes me very interested  
in the first sentence, after the list of persons  
present, because now I can ask you what you mean by  
"unexpected deaths"?

A. Well, we are back to unexpected  
and expected.

Q. But this time you used it. What  
did you mean by it?

A. Well, we arrived at that  
definition of unexpected for the purposes of this  
discussion and we said that in patients who had an  
expected death we would feel that the reason would be







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that the patient had such a severe anatomic abnormality functional disturbance that it would not be expected that he could survive. So that the death of that patient was inevitable.

Q. You are referring to what is set out as Expectation Codes on the fifth page of this document, Doctor?

A. Yes.

Q. You scored each of the deaths - and I want to come to this later - in terms of whether it was expected or unexpected; expected being in the light of the degree of specific anatomic abnormality?

A. That's what expected means. So, that meant death was inevitable. All other deaths, for the purpose of this review, we called unexpected. That was the reason. The reason for that was that we wished to do an analysis of the causes of death in a very critical fashion.

- - - -

Of course! If all the deaths were  
"exheded" (i.e. totally irresistible in  
light of the cardiac anatomy) there  
is no case for an intermediate ICU.  
Rao's def<sup>n</sup> of 'unexheded' suggests that  
many of the deaths might have  
been preventable, if only ----!



EMT.jc  
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A. There were patients amongst the group that we placed as unexpected where there might be differences of opinion amongst people as to whether or not that is a true categorization. Nevertheless we wanted to lean over in a direction that would likely end up in a more appropriate evaluation of the factors influencing death.

Q. Let me just inquire about that, Doctor.

Was there not a time element in the application of that expectation code? May I put this to you: that if I am told that I have inoperable and terminal cancer, then my death can reasonably be said to be inevitable from that cause?

A. Yes.

Q. And when my physician may say to me I will give you six months, he is projecting a life expectancy based upon my clinical and disease condition and if I were to die tonight of that condition in a very real sense my death from that cause, although properly described as inevitable, would at the time it happened I suggest be unexpected, wouldn't it?

A. I think you can make that definition. I am simply saying what we used in this





I.2

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categorization in an internal review.

3

Q All right. And therefore

4

you are telling me that a time element, the time of

5

death was not an ingredient in your classification

6

of expected and unexpected. I want to be clear?

7

A. Not necessarily.

8

Q Well, was it at all?

9

A. If in the sense that the ones

10

we put in the expected category were inevitable,

11

there were a variety of times that we might have

12

predicted.

13

Q I am sorry, I don't understand.

14

A. Well, we might have predicted

15

the death in one or two of the patients to be within

16

days and others that we might have ordinarily

17

predicted to be longer. But the death would have

18

been inevitable. So for the purposes of this

19

classification we called them expected. So the time

20

element might be variable in that group of patients

21

that we call expected.

22

All other patients we regarded as  
unexpected, and I suppose the same consideration  
might be made of that group.

23

Q Well, I am sorry, I am no doubt being

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very thick about this, and I ask you to bear with me,  
Doctor.

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If, therefore, a patient had a set of anatomic abnormalities which would inevitably cause his death, if there was no intervention I take it, or are you saying where no intervention was possible?

A. Where we didn't think it was possible to achieve anything.

Q. Oh, I see. Where there was no intervention possible and those symptoms will cause his death which may occur today or a week or a month from now, that is an expected death according to the criteria which you established?

A. Which we used for this, yes.

Q. Yes. If, on the other hand, there is a possibility of intervention so as to avoid or defer a death which would occur inevitably in the absence of intervention, and death occurs in that situation, you would call that for this purpose an unexpected death, would you?

A. Yes.

Q. All right. I just wanted to be sure that I understood the terms.

Was that made clear to everybody at the meeting?

A. I believe it was.

5'11  
but!





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Q Did people ask you what you meant by expected and unexpected?

A I think they accepted the way that we had done it.

Q All right.

A And I presume that everybody was agreeable.

Q You start:

"The apparent increase in the number of unexpected deaths on the cardio-surgical ward of both medically and surgically treated patients since July, 1980, led to the establishment of mortality and morbidity conferences in September and October of that year ...".

I am not concerned about the reference to October. I know there wasn't one.

Was there still at the time you composed these minutes, Doctor, some question as to whether there had been an actual and real increase in the number of unexpected deaths?

A No, I think not. By that time we were clear that this was a large number.

Q Was there any meaning that you intended to convey by the use of the words "apparent increase"?





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A. I think it may have been because of the grouping of expected and unexpected that we had classified perhaps more in the unexpected deaths than if we had just been doing a non-formal review.

This, as I have said, was to try and push as many patients into the unexpected group as we possibly could in order to make the analysis of the questions surrounding deaths to see if there weren't any other things we might or might not have done.

Many of those patients in that unexpected list, as you can see, were patients in whom there was terribly serious disease where it could be questioned whether you should not transfer them to the expected list, but we tried to avoid that problem so that we could really make as detailed an analysis as possible.

Q. Okay. You say half way through the first paragraph of the minutes:

"It is anticipated that similar conferences will be held at intervals where indicated on a more or less regular basis."

Were any such - were any further







I.6

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such meetings or conferences ever held?

3

A. No, we didn't have any at

4

that time. This really constituted the next one,

5

but we didn't have any conferences on that line until quite recently.

6

(2)

Q.

I am sorry, which constituted

7

the next one?

8

A.

Well, this one.

9

Q.

Oh, I see. There was not one

10

after that?

11

A.

No.

12

Q.

You then refer to the two

13

recommendations that had come out of the September

14

26th meeting, both September meetings, but essentially

15

September 26th, legible dosage cards on the crash

16

carts and proposal for meeting about the intermediate ICU.

17

Can we go to Item No. 1 at the foot

18

of page 1 of the minutes?

19

You itemize in the enclosure the

20

deaths on Wards 4A and B, July 1 to December 31, 1980.

21

Now the minutes say there were 22 of

22

those. I take it when I get to the enclosed list

23

which contains 20 names that you have removed already

24

the two which you say we really don't have to worry our heads about?

25





I.7

1

2

A. Yes.

3

Q. And as always inevitably

4

happens when one starts into a numbers game, I tell

5

you, Doctor, as you know, information available to me

6

is that there were really 21 such deaths, and maybe

7

at a later stage we can compare our lists?

8

A. I can clarify that when you

need it.

9

Q. All right. Now which of the

10

22, Doctor, were the ones described at the top of

11

page 2? That is to say terminal and expected deaths.

12

from cardiomyopathy and from pulmonary vascular

13

disease. Which were those?

14

A. These were Perreault, Taylor,

Turner --

15

Q. No, we are talking about two

16

at the moment I believe.

17

At the top of page 2 of the minutes

18

you say deaths on 4A and B for the six-month period

19

were 22 in number. Two of these were terminal and

20

expected deaths --

21

A. Oh, I am sorry.

22

Q. -- from cardiomyopathy and

23

from pulmonary vascular disease. So we have only got

24

to worry about --

25





I.8

1

2

A. Yes. Sorry.

3

Q. Which were the two?

4

A. They were Murphy and Heyworth.

5

Q. Why, Doctor, were they

6

excluded? Why were they merely not called expected deaths in the terms which you were using? Why do you sort of deal them off the top of the deck and put those away?

9

A. They were types of disease that we felt wouldn't contribute to the discussion.

11

One of them was a patient with cardiomyopathy, meaning a heart muscle disease.

12

Q. Yes.

13

14

A. And the other one had pulmonary vascular disease which is a disease of the arterial system and neither of those things are in a direct sense cardiac malformations that we would be considering in the light of what could be done.

17

18

There was no question raised about that decision at the conference.

19

20

Q. Well, there may not have been, but I confess I don't understand the rationale.

21

22

These were patients who had been on the ward?

23

A. Yes.

24

Q. And had died on the ward?

25







I.9

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2

A. Yes.

3

Q. Yes.

4

A. And were there on the ward

5

expecting - we were expecting their deaths.

6

Q. Yes. I am not quite sure

7

why they are excluded from the total number of deaths  
that need to be considered?

8

A. They are not excluded from the

9

number of deaths that are being considered. They are

10

just excluded from the detailed analysis that we

11

chose to take with reference to the patients who had

12

really congenital heart disease. They are a different

13

sort of heart disease.

14

Q. I see. I see. In other words,

15

I guess it is my failure to read between the lines.

16

What you are really concerned about, if I understand

17

you now, is deaths on the ward among patients with

18

A. Yes.

19

Q. Why? Why are you not concerned

20

about all deaths on the ward?

21

A. Well, we are, of course,

22

concerned about all deaths on the ward, but in this

23

sort of death there is no surgical intervention that

24

can possibly be made. And we did not think they

25





I.10

1

2

fitted appropriately into other - examination of  
other congenital heart malformations which is the  
bulk of what is put onto that ward.

4

5

Q All right. My misunderstanding  
of the scope of the thing.

6

7

8

9

But it is implicit in the statement  
that those two, Murphy and Heyworth, were terminal  
and expected deaths, that the cause of their deaths  
was their respective disease state?

10

A Yes.

11

12

13

14

Q That is implicit in saying  
they were terminally ill of these particular things;  
death was inevitable with them; we don't have to  
worry about what killed those two?

15

16

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A Yes, and they were different  
from the other patients.

21

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Q But different or not, were you  
really saying any more about those two than that  
their deaths and the time and the manner of their  
deaths and so on were consistent with their clinical  
disease condition?

A Yes.

Q And those charts have been  
reviewed to enable someone to come to that conclusion?

A Yes.





I.11

- 1
- 2 Q So therefore we come to a
- 3 number of 20 deaths that were to be considered, and
- 4 it is reported that their ages range from 9 days to
- 5 12 months; 9 of them were neonates. I am sorry,
- 6 my memory is awful, Doctor. The definition of
- 7 neonate is less than a month?
- 8 A About a month.
- 9 Q One month?
- 10 A A month or less, yes. Thirty
- 11 days or so, less.
- 12 Q And of the 20 it is recorded
- 13 that approximately a quarter of the deaths were such
- 14 as to be expected?
- 15 A Yes.
- 16 Q We have to say approximately
- 17 a quarter because the number may be four or five.
- 18 There was a bit of question about Turner, was there
- 19 not?
- 20 A Yes.
- 21 Q And that means in terms of
- 22 your definition in the case of four or five of these
- 23 children their deaths were not only inevitable in
- 24 light of but consistent with their anatomical
- 25 deformities and defects?
- 26 A Yes.







I.12

1

2

Q. Who were those five, please?

3

A. Those five were - they had

4

surnames of Perreault, Taylor, Turner, Monteith and

5

Gitten. Q. Gitten, yes. Turner, perhaps

6

there was some question as to whether he was expected

7

or unexpected by this definition?

8

A. Yes. We put him into one - we

9

started off with him on 2, and we eventually put him

10

Q. He was eventually put into the

11

expected category you say?

12

A. Yes.

13

Q. All right.

14

Q. So we have now approximately -

15

not approximately but exactly 5 of the 20 are expected

16

by the definition that you have given, but once again

17

that does not mean that any judgment was formed that

18

their anatomical conditions caused their death but

19

rather their deaths were entirely consistent with

20

and inevitable in light of their anatomical conditions.

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DM/ak

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A. This is, you are referring  
now to the 20, the entire 20?

Q. I am referring to the five,  
the expected ones. It means no more than this does it:  
that the deaths of those children were inevitable in  
light of their anatomical conditions and were  
consistent with their anatomical conditions?

A. Yes.

Q. It does not mean, nor is it  
ever intended to mean, I take it that their deaths  
were caused by their anatomical conditions. Because  
that would introduce a temporal element into the  
thing, wouldn't it?

A. I don't follow that question  
at all.

Q. If I have terminal cancer and  
I am going to die tomorrow morning but someone shoots  
me in the head tonight, on your coding you have put  
me down as an expected death from cancer because it  
is inevitable and it is going to happen and no  
intervention is possible, but it is not what caused  
my death, is it?

A. Except as far as I know  
nobody has ---

Q. That is not what I asked you





1

2

whether you knew it. I am only saying that on your  
classification definition it means no more than that,  
the death of these children was bound to occur in  
light of their anatomical condition, and their  
death is consistent with that anatomical condition?

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A. Yes.

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Q. And fairly, <sup>having</sup> no reason to  
suspect anything other than their cardiac defects  
as causing their deaths, [you know, without necessarily  
taking it,] I take it you are prepared to accept that  
the defects caused their deaths?

11

12

A. Yes.

13

Q. The remaining 15 you say:

14

"Death was not expected on the ward."

15

Now, again, can you explain to me what that means.

16

Because now into the definition of "expectation" you  
have introduced a geographic content?

17

A. Yes.

18

19

Q. Now did the geographic content  
enter into your definition of "not expected"?

20

A. We reached that comment,

21

I believe, from a division of those 15 patients into  
some who had come back from the operating room, and  
some who we expected might get to the operating room  
but did not; or, that we considered that was a

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reasonable assumption. Again I emphasize that we were taking the extreme position in this analysis in order to try and see whether there were things that should or should not have been changed.

Q. Well, let me be clear to you. Were you meaning this, that because of the possibility of intervention to save those children from the results of their anatomic defect, or deformity, some of them should not have been on the ward at the time they died. Perhaps some of them should have been in surgery, perhaps some of them should have been in the ICU, some of them should have come back from surgery by that time. Is that the geographic ---

A. That was the thrust of our argument.

Q. Okay, if they were going to die anyway they should have died either during or after some surgical intervention attempt. Is that the sort of thought?

A. I think that was the position we were taking. We were putting up a proposal to examine that question whether that was valid or not.

Q. And those are the children who are identified as the two in the listing at the end of the minutes, other than Turner who was





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3

transferred into the one category?

4

A. Yes.

5

6

Q. Now, you remember, Dr. Rowe,  
that you and I played the definitions game yesterday  
on the question of "expected" and "unexpected".

7

8

9

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11

12

Okay, you are in control of this one because you  
define ~~in~~ your own terms here. It follows I take it  
from your definition of "not expected" or "unexpected",  
that Bilodeau falls into that category. Although  
you and I had something of a difference about the  
expected or unexpected nature of that baby's death  
yesterday.

13

14

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A. I think that again I would  
emphasize that the definition we used here might not  
necessarily be the definition we had used in the  
course of the day to day conferences. This was a  
very specifically oriented definition of unexpected.

18

19

20

21

22

23

Q. Yes.  
A. To try and include as many  
patients in that category as we possibly could. If  
we look at Bilodeau, or if we look at Shrum, we are  
dealing with questions that do not necessarily mean  
that those patients deaths could have been avoided,  
or we might change our classification.

24

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Q. Isn't that exactly what you are

J4

*Get your  
life it was!*





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J5 saying by putting him into that category? You are conceding the possibility that there could have been intervention to prevent the deaths.

A. It depends upon the long-shot nature of your consideration, but indeed we did do that.

Q. That is indeed your definition of unexpected, isn't it?

A. Right.

Q. And therefore the question of whether they should or should not have died, could or could not have been retrieved, saved, repaired, recognizing always the variation in odds that can occur with any particular child who has a particular deformity is indeed part of this, even your definition of unexpected, isn't it?

A. Yes.

Q. Does that differ very greatly from unexpected as I was putting it to you the other day, or yesterday: that unexpected means, you know, gosh, we scheduled this kid for surgery, we expected him to survive until he got to surgery. We didn't think he was going to die last night. Is that very different?

A. Well, I think looking at this





J6

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group again I say that the - we might have different definitions for Bilodeau or Shrum in terms of the day to day conference, but for this particular purpose we are putting them into a category where we say they need not have died before they came to surgery perhaps.

Q. In formulating the definition of expected, was there any discussion between yourself and Dr.Freedom?

A. We had many discussions about this.

Q. In formulating this one for the purpose of this meeting?

A. I don't recall specifically but I believe that we did do the categorization together. So I presume that we did have a lot of discussion about it.

Q. You would hardly have expected Dr. Freedom to have applied what you call his very special definition unless he was aware of it.

A. No.

Q. Of what it was?

A. I don't recall having a formal session about that, but I am sure we must have discussed it many, many times because it is of course







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a recognized difficult area of a definition.

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Q. Do you recall any comment from Dr. Freedom, or Dr. Rose, well, that is not what I normally mean when I use the word unexpected in relation to a death?

7

8

A. I think there were discussions of that sort.

9

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11

Q. Do you have any recollection of them?

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16

A. Pardon?

Q. Do you have any recollection of such discussions?

17

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22

A. I don't, I believe there was contention about the definition. So that I can't recall the exact conversations but not everybody agreed with it until they recognized what we were trying to do.

23

24

25

Q. All right. Who were the five who died before reaching the OR, please? I am now back on page 2 of the minutes, Doctor. I am sorry, I have jumped one, haven't I: "...deaths were expected..." All right, you have identified those for me.

"The remaining 15 patients though all high risks death was not expected on





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2

"the ward. Five of the 15 died before  
reaching the OR..."

3

4

Who were they, please?

5

6

A. I should say that I in review-  
ing those minutes I have had trouble in identifying  
because I don't have the detailed notes.

7

8

Q. We know that Kelly Monteith  
was one of them because we discussed her this  
morning.

9

10

11

A. I put Monteith in the group  
of expected.

12

13

Q. Oh, yes, I am sorry. Even  
though she had been scheduled for surgery?

14

15

A. Yes, because of extensive  
damage.

16

17

Q. All right. It is one of the  
five who didn't make it into the OR.

18

19

20

A. I have a number of six. I  
realize that the statement says five, but as you can  
see I have had to go back over the minutes to  
identify them and it has been a little difficult.

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Q. Yes.  
A. So I have now got six and nine.  
I don't know whether that is a legitimate change, but  
for the purposes - perhaps it might be acceptable.





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Q. All right. And pre-operative deaths.

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5

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A. The pre-operative deaths were Gage, MacDonald, Gosselin, Shrum, Bilodeau and Lutes. Now, Lutes is not on this list.

7

Q. No, he is not.

8

A. And Hodgkinson should not be on this list.

9

10

Q. That is also true.

11

A. So what I have done in this scenario is to substitute.

12

13

14

Q. Indeed, am I not also right that Gittens did not die on the ward either, didn't he die in the ICU?

15

16

A. He was a ward related death because he came from the catheterization lab to the ICU.

17

18

Q. That is right, he went from the ward to the lab to the ICU and died there.

19

A. Yes.

20

Q. Okay, I want to be clear.

21

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A. Lutes, if I could just expand that, Lutes for some reason was missed out of the original list, we just didn't get the chart of that baby, and I don't know how we missed that, but we did.







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J10 So all that happens is Hodgkinson is excluded  
3 because Hodgkinson was transferred from the Infant  
4 Ward to the Operating Room and then to the ICU, so he  
5 never had any contact to our knowledge with 4A/B,  
6 so we place Lutes in that position then we are left  
7 with the same number.

8

Q. Heyworth you have excluded,  
he is not among the 22, not 20.

9

A. No.

10

11

Q. Okay, which four of those five  
did you say would have benefitted from ventilatory  
12 support?

13

A. Four of the six.

14

15

Q. Okay, four of the six; was it  
four of the six, or is it now five of the six?

16

A. It is six patients who are  
pre-operative.

17

18

Q. Yes. How many of those people  
could have benefitted from ventilatory support?

19

20

A. I think that in reviewing  
that I would think that most of them could.

21

THE COMMISSIONER: I'm sorry, what  
was the question?

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THE WITNESS: Six perhaps.

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MR. LAMEK: Q. Well, the minutes





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record that four of the five could have benefitted from ventilatory support. I am asking you is it now four of six or is it five of six, because we now have six in that category and not five as at the time.

THE COMMISSIONER: Thank you.

THE WITNESS: I think that it is, you know, in the minutes it says that two required ventilatory support, two others had respiratory arrest and one had ---

MR. LAMEK: Q. Am I reading a different set of minutes, Doctor? It says to me half way through the first paragraph:

"Of the remaining 15 patients, though all high risk, death was not expected on the ward. Five of the 15 died before reaching the operating room. Four of those five could have benefitted from ventilatory support."

A. It is just that the detail in the summary talks about the different types of respiratory difficulties that are being helped.

Q. Yes.

A. I would think that of the six I now have in that group, that all could have benefitted from respiratory ---





J12

*There is a  
very nice  
performance!  
Does he not  
value the  
gravity of  
this for HSE  
(and for  
himself?)*

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Q. Including the one that ---

A. Pardon?

Q. Including one who as at  
January 12th you didn't think apparently could have  
benefitted from it?

A. That is right. I think the  
patient who is excluded in the original list was the  
baby of transposition, it was Gage, and we didn't  
mention respiratory support there, we just said  
delay in reaching the operating room, possible  
delay. So I would certainly now, because the numbers  
have been changed, that might be a change, but I  
would be content to say that all those six might  
have been - at least six might have benefitted,  
at least that should be considered.

Q. All right. Now, we have  
nine postoperative?

A. Yes.

Q. And I guess we could all do  
the elimination process, you have done it, could you  
just give us a list of the names, please?

A. Yes. Nine postoperative  
Velasquez, Hoos, McKeil.

THE COMMISSIONER: Yes, and after  
McKeil?





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THE WITNESS: Lombardo, Onofre.

3

THE COMMISSIONER: I'm sorry, what

4

name was that?

5

THE WITNESS: Onofre, it is about

6

four from the bottom.

7

THE COMMISSIONER: Yes, thank you.

8

THE WITNESS: Dawson, Adamo,

9

Volk and Belanger.

10

MR. LAMEK: Q. And in the minutes

11

you say of those ten, and now of those nine, one is

12

associated with medication and that I take it to  
be Velasquez?

13

A. Yes.

14

Q. And five you said represented

15

examples of failure to intervene with re-operation,  
four others should have been in a more intensive  
monitoring care situation as possible on the ward.

17

Can you, Docotor, just identify the ones to whom  
you're referring in that sentence?

18

19

A. The five where there was

20

question of re-operation.

21

Q. Yes.

22

A. They are McKeil, Lombardo,

Onofre, Dawson. Are my numbers right now?

23

Q. That is four.

24

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Rowe  
dr.ex. (Lamek)

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BMcra 2

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Then there was the question, which is Velasquez, and then there are four where the question of re-operation should have been perhaps considered and then there are four where an intermediate intensive care setting might be considered. There is Adamo, Volk, Belanger and Hoos.

MR. LAMEK: Mr. Commissioner, on the hour of one o'clock, is it time for a break?

THE COMMISSIONER: Yes. We will resume again at 2:30.

--- luncheon recess.





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--- on resuming.

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THE COMMISSIONER: Mr. Lamek.

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MR. LAMEK: Thank you, sir.

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Q. Dr. Rowe, we were dealing with the meeting on January 12, 1981. I believe we had come to that part of the discussion at that meeting at which the proposal or suggestion of an intermediate intensive care unit was being canvassed and you had enumerated for me those children who fell into the different categories described in the paragraph at the top of page 2. I'm sorry, we were just about to come to the intermediate intensive care unit. Because of those fifteen for whom the category "unexpected", as you defined it, was used, the last sentence of the first paragraph is:

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"Five represented examples of failure to intervene with reoperation and four others should have been in a more intensive monitoring and care situation than is possible on the Ward."

20

21

And you had identified those four as being Hoos, Adamo, Volk, and Belander, I think, and that was the point we had come to.

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THE COMMISSIONER: No, not yet, at least not in my notes.

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MR. LAMEK: Oh, I've got Belanger on my notes "with greater care".

THE COMMISSIONER: No, no. The four should have been in more intensive monitoring and care were who?

MR. LAMEK: I thought they were.

Q. Perhaps you can tell us again, Doctor.

A. I believe they were Adamo.

Q. Yes.

A. Volk.

Q. Yes.

A. Belanger.

Q. Yes.

A. Hoos.

Q. That's what I thought I said a moment ago.

MR. ORTVED: You did.

MR. LAMEK: But not in that order - I had them as Hoos, Adamo, Volk and Belanger, and it was thought that those four perhaps should have been in a more intensive monitoring and care situation than is possible on the Ward.

Q. Are you able to tell me, Doctor, what degree of monitoring and care you thought they







Rowe  
dr.ex. (Lamek)

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should have been receiving? I guess what I'm asking is, how high is up!

A. I think that all those four we considered were particularly susceptible to changes that might tip the balance in the sense that Volk had a lung problem as well, Hoos had a chylothorax, which is a collection of fluid in the chest, and Adamo perhaps could have benefitted from a stay for a longer period in the intensive care.

Q. I think, Doctor, you told me why you thought those patients were candidates for a higher level of care.

A. Yes.

Q. But I think my question was, how much higher than they were able to receive on the Ward?

A. Somewhere between the Ward and the Intensive Care.

Q. Somewhere in that area?

A. Somewhere in between the Ward and the intensive care level.

Q. In considering that as perhaps something that would have helped those children, did you notice in looking at the charts whether constant nursing care had been ordered for any of them?

A. No, I don't believe I did.

Ross's thesis was that a higher level of care was required than could be given on the ward,  $\therefore$  need intermediate care

But he didn't know and didn't check whether any enhanced level of nursing care had been ordered on the ward! If he didn't know how much care these patients were receiving, how could he say they needed more

Reasonable to believe that if Dr X thought a patient needed enhanced care he would have ordered it and, in the climate which prevailed, would have raised hell if told the enhanced care was not available.

Why not the Head Nurse give Ross a light on the intermed. care issue. Anything that might get dying patients off the ward and reduce the tension and poor morale of the floor nurses would of course have their support.



Rowe  
dr.ex. (Lamek)

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Q. Would that not have been an important consideration in deciding whether greater care than is available on the Ward was appropriate?

A. I don't have the same confidence that you have in the notations necessarily on that point. But I think that if there had been any issue in that regard at this conference, that would have been addressed by the nursing group.

Q. I'm not sure I understand that. But let me ask the second half of the question.

Was there any notation that you saw on any of the records of these four children to suggest that an enhanced level of care had been ordered for them?

A. I'm not sure of it because I'm not sure whether there were notes on those charts at all because that point was not specifically examined by me.

THE COMMISSIONER: I'm sorry, what was that you said?

THE WITNESS: I'm not sure whether there were notes to that effect or not on those charts because that point was not specifically addressed by me.

THE COMMISSIONER: But I thought you said something about it would not have been appropriate,







Rowe  
dr.ex. (Lamek)

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or it would have been appropriate. Did you say anything about that?

THE WITNESS: No, I don't think so.

MR. LAMEK: I didn't hear Dr. Rowe say that.

THE COMMISSIONER: No, but I thought you may have said something -- I am just really, I guess, following up Mr. Lamek's question. Would it have been appropriate to have ordered constant nursing care or shared care or anything of that sort?

THE WITNESS: Yes, yes, that would have been, for most of those patients.

MR. LAMEK: Q. I guess my concern is this, Dr. Rowe, if it was your opinion that those four children should have been receiving a higher level of care and monitoring than is normally available on the Ward, would it not be relevant to know whether they were at least being provided the highest level of care that the Ward could afford to them?

A. Yes.

Q. That is to say constant care?

A. If that was available.

Q. Well, did you make any enquiry as to whether it was available?

A. I don't recall doing so.





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Q. Did you make any enquiries as to whether it was requested?

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A. No, I don't remember doing so.

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I would remind you, however, that this conference was a provocative type of conference in which we were proposing far to one side what we thought might be the appropriate thing to do, to test to see what people thought about that suggestion.

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Q. Well, I take it, Doctor, that the idea of an intermediate intensive care unit is, forgive me, I don't mean to be offensive, a little like motherhood - it is hard to oppose it in concept, isn't it?

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A. Well, I think the nurses might have had very significant reservations about it.

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Q. Well, they didn't express them in any event, you are saying?

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A. Not at this conference, no.

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Q. All right.

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And as I understand you, just so I am clear, while saying that these four children should have been in a more intensive monitoring and care situation than is possible on the Ward, you had not made an enquiry and, to your recollection, didn't have any information as to whether the highest level of







Rowe  
dr.ex. (Lamek)

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care that might be available on the Ward had been ordered for them?

A. Right.

Q. Well, does it come to this, Dr. Rowe, that all of the deaths which you classified as "unexpected", by your definition, all but one; that of Velasquez, at the end of this meeting, appears to have been explained by the conclusion that if only the surgeons had moved faster to reoperate and if only a higher level of care and monitoring were available, those children might not have died.

That's a rather terse way of putting it but it is it an unfair way of putting it?

A. I think it is unfair.

Q. Well, you tell me then on what basis, if at all, you were able to resolve the unexpected nature of those deaths?

A. Well, I think what we were doing, as I have said before, in order to go as far as we possibly could to examine whether any management change in these babies might have produced any difference, we put the provocative proposal that some babies should have gone back to surgery earlier. If we get eventually to some of these babies, as I presume we will --





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Q. Yes.

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A. -- then it will become evident that in some situations where theoretically a return to the operation room might have been desirable, the practical severity of the malformation was such that that might not have done the job.

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Q. It might not have made any difference.

A. And it was in that sense that this examination was made. I think it would be totally unfair to the parents of those children or to the surgeons to suggest that there was a frank failure to reoperate when the conditions were not loud and clear.

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Q. Believe me, I didn't mean to create that impression as being the outcome of the meeting. Forgive me if I did.

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But you had fifteen deaths which you classified as unexpected in the sense that -- well, what was the definition again - they warranted further review, and they had died on the Ward. Would some intervention have made a difference?

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A. Yes.

Q. And you were able to suggest at the end of the meeting, were you not, that in one way





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or another if facilities were available and so on,  
perhaps some intervention might have made a difference.

A. I think that was the conclusion.

Q. Okay. And that's a fairer way  
of putting it, I acknowledge.

A. I think so.

Q. And the meeting then it seems  
got into a discussion of the ICU, the proposed  
intermediate ICU, and perhaps more cardiovascular  
surgeons doing perhaps more aggressive reoperations  
and so on. But there were questions about a few  
things that, from my reading of these minutes, do  
not appear to have been said or raised, Doctor. Per-  
haps you can help me.

Did you or did anyone else at this  
meeting say expressly that the increase in ward  
deaths was attributable to a higher incidence of  
very serious cardiac problems? Was that advanced  
as an explanation?

A. I think that may have been. I  
don't recall. I haven't made a note to that effect  
and I don't recall.

Q. Now that was in fact, if I under-  
stood your evidence this morning correctly, the view  
to which you still tended to subscribe, wasn't it?







Rowe  
dr.ex. (Lamek)

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A. Yes, I would assume we hadn't incorporated that here because everybody was agreeing with that situation and we went into the conference with that, without any disagreement about that issue.

Q. Doctor, you are suggesting to me that the things that you unanimously agreed upon don't appear in the minutes, or are you suggesting that that was too obvious to bother stating?

A. Yes.

Q. Everybody started with that as a premise?

A. That's right. That is my understanding of that.

Q. And you recall, therefore, no discussion on that point? It wasn't worth discussing; everybody agreed on that?

A. Yes.

Q. Did anybody remark on the fact that a substantial number of these Ward deaths had occurred in the early hours of the morning?

A. I don't recall that, but I am quite sure it must have been mentioned. But I don't recall that there was a major issue about that either.

Q. Forgive me, Doctor, I don't mean to be facetious or contentious but what does appear in





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the minutes?

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A. Most of the important things  
that we discussed and agreed upon.

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Q. But you are sure there must have  
been some discussion of the question of the timing  
of these deaths but there is no reference to that in  
these minutes?

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A. No.  
Q. I take it from the follow-up  
comment that you made, that if that comment was  
made or if there was any discussion, it was not  
regarded as an important observation?

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A. Or that it wasn't disputed in  
any way or that people didn't think it was of the  
greatest order of importance.

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Q. All right.  
Did anybody at the meeting say that  
there was a shortage of nursing on the night shift  
on Wards 4A and 4B?

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A. I don't know whether anybody did  
or not. I don't recall.

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Q. Did anybody say, Doctor, the  
establishment of an intermediate intensive care unit  
is great but it's a long way down the road, what are  
we going to do now to stop this run of deaths? Did





Rowe  
dr.ex. (Lamek)

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anybody say that?

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A. No.

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Q. Was there no concern expressed

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at the meeting to try to find an immediate explanation

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and solution to what was, as of the end of December,

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an immediate problem with five deaths in that month?

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A. Yes.

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Q. Was there discussion to that

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effect?

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A. No. I think that we were trying

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to look at the whole six-month period and we were not

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looking at that particular moment at the last five

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cases.

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Q. Well, did anybody say, well,

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what's going to happen for the next six months until

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we get the intermediate ICU? Are these deaths going

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to continue, Dr. Rowe? Did anybody ask that question?

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A. I don't believe anybody did.

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Q. Did it occur to you to ask that question to yourself?

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A. No. I don't believe at the time. I think that at the time we felt that if we could get on with this unit we probably would

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resolve the issue. At least we might resolve the issue. I don't think we were sure about that because we recognized that this was a large number of infants who were seriously ill but we hoped that it might improve the situation.

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Q. Doctor, if the proposal for an intermediate intensive care unit were to go forward, what was your expectation as to when that proposal might be implemented?

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A. I thought within a couple of months. Two or three months; maybe earlier.

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Q. Well, it was agreed by the people at the meeting the next step would be to form a small subcommittee headed by Dr. Fowler:

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" ... which would include the head nurses of the cardiac ward, cardiac surgeons and a representative of the physicians in ICU so that decisions can be made concerning the size of such an intermediate intensive care unit,

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"where it should be sited, how many extra staff would be necessary and what equipment items would be required. ... their conclusions would serve as the basis for an application by Drs. Trusler and Rowe to the Program Advisory Committee if necessary."

What is the jurisdiction of the Program Advisory Committee?

A. Well, that committee assigns priorities and considers the validity of the requests for a new program.

Q. Did the recommendation - I am sorry?

A. Which this would constitute.

Q. Did the matter proceed as recommended at the foot of page 3 of the minutes? Was a small subcommittee formed?

A. Yes, it was.

Q. And did it consider the matters that were assigned to it?

A. Yes, it did.

Q. And on the basis of their conclusions was an application made by yourself and





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Q. Did you have an impression or a perception as the months went by from July through to December that the incidence of severe illness was continuing at the same level that you had observed in July and August?

A. No, I think it fluctuated somewhat, but there was still an ongoing large number of babies, but I think the clustering was most marked in July and August, and then started - fell right off in November but started off again in December.

Q. Which happens to be the month in which the five mortalities occurred?

A. Yes.

Q. Which I take it are indicative of the seriousness of the illness of the patients?

A. That is what we believe.

Q. Other than your observation that the mortality rate seems to have declined in November when, as I understand it, you were away, do you have any information as to the severity of illness of patients who were admitted in November?

A. No, I don't have that information.

Q. And therefore to the extent you believe there was a fluctuation and November was





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a month in which less seriously ill patients were coming in, that is a reflection of the fact that in November there was only one mortality on the ward?

A. I would make that assumption.

Q. Is that not an entirely circular argument? ~~the~~ <sup>the</sup> deaths are high because the patients are seriously ill; how do you know they are seriously ill? Because their deaths are high?

A. I can only tell you that I get the reflection of those fluctuations from the staff who were involved and the ward chiefs.

Q. Yes.

A. I think if you wish to question on those items month by month you would have to speak to the ward chief of the month.

Q. Right. I shall have to do that, Doctor, thank you.

Can we go now to the babies who had died and who were reviewed and categorized for the purpose of the meeting on January 12th? We have covered some of them, of course, and I don't intend to go over them again, and I think we resolved the differences between your list and mine, Dr. Rowe.

I had wondered why Laurette Heyworth and Paul Murphy and Matthew Lutes were not on. I









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know now why the first two were not on and Lutes  
should have been, as I understand it.

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And on the other hand my list does  
not include Hodgkinson and Gittens because my list  
comprises those who died on the ward and those two  
did not.

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Now we have already discussed  
Bilodeau, Turner, Taylor, Shrum, Velasquez and  
Monteith in the context of the September conferences,  
and other than the classification of Bilodeau - and  
was it Shrum too?- as unexpected by the definition  
that you adopted --

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A. Yes.

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Q. Other than that --

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MR. SCOTT: Mr. Commissioner, I  
wonder if I could just interrupt?

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THE COMMISSIONER: Yes, Mr. Scott?

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MR. SCOTT: This is going to be a  
very long examination in chief. Indeed for a moment  
I thought we were in cross-examination, but it is  
going to be a long examination and it may take some  
time.

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At the stage that just ended Mr.  
Lamek had gone through a series of questions in which  
he asked the Doctor about things that he did in the

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months running from September through to December.

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It seems to me fair at this stage we should not have to wait until the end of the case. It seems to me fair at this stage that if Mr. Lamek thinks there is something that the Doctor should have done at that time, it seems to me fair to the Hospital that I represent that that should be put to Dr. Rowe now so that he can comment on it.

THE COMMISSIONER: I thought he had done that. Perhaps he hasn't.

MR. SCOTT: No.

THE COMMISSIONER: Have you anything further that you want to --

MR. SCOTT: What does Mr. Lamek think should have been done? He is making criticism, as I understand - very gentlemanly and in polite fashion he is making - he is presenting questions that suggest obliquely that the determinations made and the course of conduct followed up to December were not adequate. What were you going to do for the next 16 months? Just wait until you had more deaths?

Now I don't object to those questions, but it seems to me in fairness that if Commission Counsel has something that he thinks should have been done this doctor in the witness box should be allowed





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to hear what that is and be allowed if he wants to  
make a comment about it.

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Now I don't act for Dr. Rowe so this  
interjection is made on behalf of the Hospital. What  
has happened is we have now gone off this exchange  
and whatever Mr. Lamek thinks should have been done  
has not been put to the Doctor.

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THE COMMISSIONER: Well, can I just  
make a guess that what he has in mind that perhaps  
he is suggesting that Dr. Rowe should have done what  
we are doing now: try to find out the cause of death  
of these children.

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MR. SCOTT: Well --

THE COMMISSIONER: That there may  
have been something else that could have been done.

MR. SCOTT: Well, obviously I accept  
that and I think that the evidence reveals that the  
Hospital and the doctors and staff were concerned  
about that and were doing certain things. Is there  
something else that Mr. Lamek says he should have  
done in December? If there isn't, fine, but if there  
is I think fairness requires that we know what it is.

THE COMMISSIONER: Well, I will let  
you answer that if you want to, Mr. Lamek.

MR. LAMEK: Mr. Commissioner, only





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to this extent! I hope Mr. Scott knows me well enough that he would not think I would be deliberately unfair.

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MR. SCOTT: Oh, no.

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MR. LAMEK: I know that. In the course of some of the questions I have I hope suggested to Dr. Rowe things that he might have done.

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I suggested, for example, that some attention to the questioning of the timing of deaths might have been appropriate, but I have heard from Dr. Rowe that that was not a thing that they addressed.

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Beyond that I have nothing specific by way of a panacea to questions that might have been arising at the time. If I had I would put it to Dr. Rowe.

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I am concerned to know what he was thinking about and equally what he was not thinking about and that is the thrust of the examination as far as I am concerned.

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MR. SCOTT: I am quite satisfied if my friend wants to ask the Doctor did you think about this, did you think about that? I have no quarrel with any of those questions, but I rather got the implication that my friend was saying I know







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something that I think you should have done in  
December.

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We are all second guessing to a  
certain extent, and I now have his assurance that  
he has no suggestion to make as to what should have  
been done in December except to review the history  
of the deaths, and I am content.

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THE COMMISSIONER: Well, Mr. Scott  
is happy.

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MR. LAMEK: If Mr. Scott is happy  
then I am happy, Mr. Commissioner.

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MR. SCOTT: As long as we have that  
rule established.

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MR. LAMEK: Then happiness may not  
be that important to me.

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Q. We have already talked about  
Bilodeau, Turner, Taylor, Shrum, Velasquez and  
Monteith. In the course of preparing for the meeting  
of January 12, 1981, Dr. Rowe, had your views as  
you have given them to us in the course of yesterday  
and this morning, had your views on any of those six  
deaths changed in any way between the end of September  
and the middle of January?

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A. My views on the --

Q. On the six whose deaths we  
have already canvassed here in this hearing?





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A. No.

Q. Thank you. Then taking the children in chronological order, let's look next to the case of Alan Perreault.

Once again we have behind you and to your right a diagram purporting to represent the structure of the heart of this child.

In your review of the chart does that accurately depict the state of Perreault's heart?

A. Yes.

MR. LAMEK: May that be the next exhibit, Mr. Commissioner, please?

THE COMMISSIONER: 66.

--- EXHIBIT NO. 66: Heart diagram of Alan Perreault.

MR. LAMEK: Q. Could you please, Doctor, describe the defects and anomalies that appear in the heart of this child?

A. Yes. This boy had the most extreme form anatomically speaking of hypoplastic left heart syndrome. That is a spectrum of several anatomic abnormalities on the left side of the heart.

The right side is rather much the same as in a normal situation except that it is enlarged considerably as a consequence of the disease on the other side.





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But if we specifically look at the left side of the heart there is an extremely small chamber to the left ventricle as contrasted with the normal over here (indicating). The mitral valve is what is known as atretic.

Q. I am sorry, Doctor?

A. Atretic being it is not patent at all. It is really absent.

There is a valvular structure there but it is completely sealed. There is no exit from the left atrium above into the pumping chamber below. So mitral atresia is the term given to this association.

In the aorta, the aortic valve is also atretic, so that in fact there is no entrance into the pumping chamber and there is no exit from the pumping chamber.

Consequently for a baby to survive there has to be some way in which the blood which is being pumped out to the lungs can return to the left side of the heart and then get somehow or other out into the circulation.

Since it cannot go down here and cannot go out there, it has to go somewhere else to mix with the other side, and it is usually possible through a foramen ovale or small communication in the







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atrial septum or wall between the two atria here,

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there is a small aperture like a trapdoor called

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a foramen ovale.

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3 That is a mechanism by which blood can get to the  
4 left side of the heart during the fetal existence  
5 of the baby, but after birth that tends to stay  
6 over. About a quarter of the population has a  
7 permanent trapdoor there, but it does not result  
8 in any abnormality because it is kept shut by the  
9 pressure relationships.

10 In these babies that is necessary  
11 for survival usually. So that blood can then go  
12 across through this left side of the heart to the  
13 right arteria, through this trap door, which it  
14 mixes again with blood from the vena cava. So you  
15 have got again the Waring blender issue of a mix in  
16 the right atrium. Blood will then go down into the  
17 right ventricular which is therefore receiving much  
18 more blood than it would ordinarily do, and therefore  
19 enlarges, and blood goes out into the pulmonary  
20 artery which also enlarges, and the ductus arteriosus  
21 which is up here remains open. Then blood that goes  
22 through the ductus arteriosus, blood will go through  
23 in this direction and perfuse the body through the  
24 aorta and go backwards around here right down to the  
25 coronary arteries. But this structure is very, very  
small, it is about two to three millimetres in  
diameter in this situation as opposed to something





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3 about three times that size normally.

4 It therefore becomes clear that what  
5 really determines how well a baby with this situation  
6 might do, is how long this structure, the ductus  
7 arteriosus, which is a very unreliable vessel,  
8 remains open. The moment it starts to close there is  
9 no way in which blood can perfuse the essential  
10 organs of the body. So there is a situation of  
11 rapid deterioration and death.

12 This particular baby at autopsy had  
13 no communication between the two top chambers. We  
14 can only assume that that communication was sealed  
15 during the course of its life after birth, at a later  
16 stage. That is why I categorize it as perhaps the  
17 most severe case because the only other way blood  
18 can communicate with this side would be through a  
19 little hole in the coronary sinus that I talked about  
20 with one of the other babies, that circles around  
21 the back of the heart and drains into the side, or  
22 through vessels in the lung. The usual and expected  
23 age of death in this sort of baby, who really dies as  
24 this thing shuts off, is about four and a half days.  
25 That is, some babies at one or two days, some babies  
die at six or seven days and only exceptional babies  
live much longer than the week.





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3 The unusual thing about Alan Perreault  
4 was that we predicted that he would be dying and  
5 very shortly after a diagnosis was made and he  
6 survived for a considerable period of time. But  
7 generally speaking when we make this diagnosis in  
8 our hospital today the patient is transferred back  
9 to the <sup>refusing</sup> hospital (laboratory), because there is no  
10 successful intervention for this type of child that  
11 is conducted in our institution.

12 It is really in the realm of  
13 inoperable or possibly heroic surgery, if one were  
14 to try anything. A number of attempts have been  
15 designed to do this but so far there haven't been  
16 any with convincingly good results. So it is  
17 regarded as a situation where death is inevitable.

18 Q. Doctor, thank you. Clearly  
19 from what you have said there was nothing that your  
20 Division or the Cardiovascular people could do for  
21 Alan Perreault. He was admitted on June the 25th  
22 I think and when he died he was 27 days old.

23 It appears from everything that you have  
24 said that what was unexpected in any sense of the  
25 word about Perreault was not that he died but that  
he survived so long, is that right?

A. Yes, that is the situation.







Rowe, dr.ex.  
(Lamek)

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When I referred the other day to the fact that we were worried about his survival, of course I meant that there was a little concern that the longer he went on that perhaps there had been a serious error of diagnosis.

Q. Now, Doctor, it appears from the chart, and I think indeed your note at page 50 of the chart.

A. I am sorry ---

Q. Have you found that yet, I think that is your signature against the order of June 25th, the date of admission.

A. Page?

Q. 50.

A. That seems to be the one page that is missing in my book.

Q. It is on the back of the other page, yes, there it is.

A. I am sorry.

Q. I think that is your signature, is it not there on the right hand side.

A. That is a confirming signature.

Q. Yes. The order is: "Do not resuscitate", and I take it that order was written after consultation with the consent of the parents?





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A. Yes.

3

Q. And it had been decided again  
in consultation with the consent of the parents  
to provide no active treatment for this baby, had it  
not?

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7

A. Just supportive.

8

Q. Just supportive and keep him  
comfortable?

9

A. Yes.

10

Q. But when in fact Alan  
Perreault survived beyond a week and into the early  
days of July you have said, the case was reassessed,  
wasn't it?

13

14

A. Yes, it was.

15

Q. Because since he was not  
expected to live so long, as you have said, you have  
to wonder whether the diagnosis could have been right.  
At page 30 -- I am sorry, the reassessment notice  
at page 45 of the chart I think.

18

19

A. Yes.

20

Q. And that I believe to be your  
note as well, Doctor?

21

22

A. It is.

23

Q. And in it you record as I  
read your handwriting at the bottom:

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"Impression. I do not doubt the original diagnosis is correct.

I see no grounds to suggest improvement has occurred - the signs indicate slow deterioration. Whether anatomic variants are responsible for the unusually long survival (at present 20 days) is debatable but there are no unusual features except that the left ventricular may be slightly larger than average size in one echo mode."

A. Yes.

Q. "My own view would be not to study further or intervene at this point."

In other words, having made the reassessment you were satisfied with the validity of the diagnosis. Although it was a matter of I take it some wonderment that the child had survived as long as he had there really didn't seem any basis to consider doing anything other than what had already been done.

A. Yes.

Q. There is one thought however, in the final paragraph of your reassessment report.







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You say:

"Originally he was considered a candidate for attempted experimental surgery but didn't satisfy our criteria for entry to the study then because of bleeding problems. Possibly that decision could be reconsidered if there is no further change over the next several days."

An eventuality, I take it that you thought to be highly unlikely.

A. Yes.

Q. "If that were decided hematologic study and probably cath/angio would be indicated and diuretic started."  
I plan to consult with Drs. Izukawa, Freedom and Trusler on that issue, and discuss the situation further with his parents."

And indeed you did discuss the situation with the parents, did you not, Doctor, and they said they would get back to you, they would think about it and decide what they wanted to do. And events eventually overtook them and on the day





008  
1  
2 that they were to get back to you in fact the child  
3 died, did he not?

4 A. Yes.

5 Q. The child died on July 8th  
6 in the early afternoon. Could we turn to the  
7 Progress Notes, the nursing notes for that child,  
8 page 43 of the chart. The notes appears to be that  
9 of Miss Morin and (later Mrs. Trainger) dated June  
10 8th, 1980 covering the period from 7:30 a.m. to  
11 1:45 p.m.:

12 "Feeding baby at 12:30. Baby did not  
13 void all day. Remained very tachypnic  
14 and air hungry but sucking eagerly on  
15 bottle. Approximately around 3:15  
16 baby began to Cheyne-Stoke."

17 That is the breathing associated with  
18 dying, isn't it, Doctor?

19 A. Yes.

20 Q. "Colour became quite pale and  
21 slightly cyanosed but no improvement  
22 noted with oxygen. Dr. Contraras  
23 notified. No breath sounds heard.  
24 ECG monitor showing occasional  
25 ventricular activity. At 13:45 baby  
had absent respirations and absent apex.





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"Dr. Contraras called again and baby was pronounced dead."

So Baby Perreault died on August the 8th. He seems to have died very quietly, Doctor. The notes suggests that almost, and I don't want to sound maudlin about this, but just drifted away as it were, that is the picture that is painted by the note, isn't it?

A. Yes.

Q. Doctor, I have to put to you that that death is in very sharp contrast to the sequences that we were referring repeatedly yesterday, was it not?

A. Yes.

Q. Now, here was a baby who was certainly very seriously sick, and inevitably would die as you have said. I asked you yesterday whether the pattern of terminal events that we were seeing was common, and I don't suggest for a moment that one can base anything upon this one child, but nevertheless here is one baby who certainly fits the bill of a very, very sick child. The manner of his death was entirely, entirely different from anything that we have looked at so far. Is that a matter of any significance in the exercise on which we are engaged, Doctor?





CC10

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A. No, I don't believe so. He

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had been in - despite the suggestion that he had

4

been stable, he had been in chronic congestive failure.

5

The huge surprise of course had been that he hadn't

6

died before.

7

Q. Yes.

8

A. That he had signs of gallop

9

rhythm and bad congestive failure, his liver was

10

6 centimetres below the custom margin so he was

obviously getting worse.

11

Q. Yes.

12

A. Getting worse over time, so

13

his condition was really not stable. I think if you

14

compare the notes from the 5th of July to the 7th

15

and they are written by a cardiologist, the notes I am  
referring, there is a change.

16

Q. I don't suggest he was stable,

17

Doctor, indeed the pattern is one of slow and steady

18

decline.

19

A. Deterioration.

20

Q. Until fatal entirely?

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A. Yes.

22

Q. In very sharp contrast to what

we were seeing yesterday. That is quite often a

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pattern of stability and then a very sudden and

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rapid decline with dramatic terminal event?

A. Yes.

Q. Were the circumstances of Alan Perreault's death consistent, in your view, with anything other than death that you expected in light of his anatomical condition?

A. I think they are quite compatible with his anatomical condition.

Q. Are they consistent with anything else, that pattern of death?

A. His heart rate here, I don't see notes on it.

Q. No suggestion of arrhythmia there, is there?

A. No.

Q. Or seizure activity?

A. No. He was having occasional ventricular activity which means his heart rate must have slowed.

Q. Yes.

A. So that his heart rate slowed before he died.

Q. Yes.

A. I don't see a note saying when that happened but I presume, I am trying to see





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(Lamek)

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the record on this chart where the nurse decided  
that Dr. Contraras should be called, as compared to  
where the baby was at some notated time before that.

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The record is a little cut off on one margin on my copy. Approximately around (something) the baby began to <sup>change</sup> ~~change~~ Stokes but prior to that had been sucking eagerly on the bottle. So that presumably something happened at that time and from that time to death was - I can't tell from this - half an hour.

Q. Half an hour.

A. So that the deterioration appeared there to be rapid. The sudden change in the condition appeared to be rapid.

Q. Well, I suggest to you, Doctor, that this is not the suddenness of change that we were seeing yesterday. It is not the dramatic change that we were seeing yesterday, is it?

A. Well, it is certainly sudden.

Q. You mean from the time he begins to do that characteristic breathing, Cheyne Stokes; it is a mere half hour later that he's dead?

A. Yes.

Q. But in the meantime he's not going through various arrhythmias, is he, and he's not having seizure activity and he's not doing any of the things we've seen yesterday. He wasn't vomiting.







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A. I don't know what the nurse means by "ECG monitor having occasional ventricular activity, but I assume that that could mean either that there was no heartbeat except for occasional beats or that there was occasional ectopic activity.

Q. Yes.

A. Irregularity.

Q. Yes.

A. I think if there was no heartbeat except for occasional ones, that would have been a cause for getting someone in to collaborate with the nurse.

Q. Except the orderlies <sup>is,</sup> ~~lies~~ do not resuscitate on this?

A. No, I didn't mean to resuscitate; I just mean to confirm that that was happening.

Q. Well, perhaps we can clarify that later if we hear from Miss Nelles.

Doctor, can we have a look at the chart of Amber Dawson.

MR. STRATHY: Is that to be marked as an exhibit, the last one?

THE COMMISSIONER: The word "chart" is going to give us some trouble. I prefer "diagram" for this and "medical records" for the other. So, we





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don't use "chart", or we will be at cross-purposes.

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So, you are referring to the medical records then of Dawson?

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MR. LAMEK: Yes, please.

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THE COMMISSIONER: Exhibit 59.

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MR. LAMEK: Yes, please, and the Dawson diagram.

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MR. SHANAHAN: Mr. Chairman, if I might interrupt for a moment. It is probably an appropriate time. It is an issue that I was going to address today in any event.

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THE COMMISSIONER: Yes.

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MR. SHANAHAN: I was contacted late yesterday by the family of the Dawson infant, by Heather Dawson, her mother, and asked at this late date to put to the Commission her desire that their family have standing here in the Commission.

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I believe that some time ago they had received the Commission correspondence that was addressed to all parents, but for reasons best known to themselves have decided at this moment to act and they request that we put to you their desire, as I said, to have standing here along with the other parents and that, if that standing is granted to them, their interests be represented by myself throughout





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the Inquiry.

And as we head into the Dawson child, I had intended to address the issue later as we closed the day but, with us heading into it now, it's as good a time as any to bring that up.

THE COMMISSIONER: Yes. Well, there is no problem about it, Mr. Shanahan. Any parent is entitled to have standing and if their standing is through you, that is, of course, quite satisfactory.

MR. SHANAHAN: Thank you.

MR. LAMEK: Mr. Commissioner, I'm in your hands. It is 3:30 and I think it likely that I can get through the Amber Dawson file in the next little while. Maybe you would prefer to go straight through without a break in the hopes of ending a little earlier today, but it is entirely up to you, sir.

If you propose to take a break, this might be a convenient time to do it, before we start the Dawson child.

THE COMMISSIONER: Well, how long, if you went -- how long would the Dawson matter be, do you anticipate? About half an hour?

MR. LAMEK: Probably not more than that.

THE COMMISSIONER: Well, could I have a





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show of hands whether we have a break or not.

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Those in favour of a break, please?

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Those opposed?

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Break it is then. We will take  
ten minutes.

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MR. LAMEK: What could be fairer than  
that.

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--- short recess.

9

--- on resuming.

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THE COMMISSIONER: Yes, Mr. Lamek.

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MR. LAMEK: Thank you, sir.

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Q. Doctor, we're moving on to the  
case of Amber Dawson, who died I believe on July 28,  
1980 at eleven months of age.

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Amber Dawson, am I right, Doctor, was  
no stranger to the Hospital For Sick Children, she  
had undergone surgery at the Hospital at the age of  
one month, did she not?

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A. Yes, she had.

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Q. And at nine months she had been  
readmitted for further surgery.

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Q. And then on July 23, 1980, at  
the age of eleven months, she came back into the  
Hospital For Sick Children.







DD6

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A. Yes, she did.

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Q. And, indeed, the size of the  
chart or record that we have for her reflects the  
fact that there were three admissions?

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A. It does.

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Q. Yes.

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Now, again behind you and to your  
right, Doctor, there is a diagram of what purports  
to be the heart of Amber Dawson. Do you so recognize  
it from your knowledge of this file?

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A. I do.

12

MR. LAMEK: May that be the next  
exhibit, Mr. Commissioner, please.

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THE COMMISSIONER: Yes. Exhibit 67.  
--- EXHIBIT NO. 67: Diagram, Amber Dawson.

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MR. LAMEK: Q. And could you,  
Doctor, again describe the cardiac problems of this  
child and, if you can, at the same time the nature and  
results of the two earlier operations.

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Doctor, I have been asked to make this  
request of you, please - people are anxious to make  
a note of your description of the heart - could you  
perhaps take it a little more slowly.

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A. I'll try.

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Q. Thank you.

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Rowe  
dr.ex. (Lamek)

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A. This diagram is a little different from others because it represents the state at the time of the last admission. But I can tell you that in the initial stages, the defects were principally those of communication between both the pumping chambers and the receiving chambers, the ventricles and the atria.

So, there was a defect or a hole at the atrial septal level, a hole allowing blood to pass from the left atrium to the right.

At the lower level between the pumping chambers there were several holes and at least three, I believe, required repair, and these were of various sizes and existed prior to their repair so that blood could go from the left side to the right.

All the other structures in the heart appeared to be normal as far as I can recall.

So, the problem was simply that of a large defect here and a series of defects below, all of which tended to result in blood pouring through from the left side of the heart to the right.

So that at this level of the heart, the atrial level, there was a mixing with the oxygenated blood from the left side, and this went down into the right ventricle where it received more additions





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of highly oxygenated blood and a huge amount, therefore, of blood flowed out to the lungs where it was distributed and came back again fully oxygenated. Some of it would go through again here (indicating); the rest of it would go down here and another increment would go across at ventricular level and, then, what was left would go out into the aorta.

Now, this was a fairly massive amount of what is called left-to-right shunting, and that led to the appearance of this baby at about three weeks of age in this institution, I think, and at that time the baby was in congestive heart failure.

The other thing that is of importance in this baby was that this baby was small for gestational age - that means that she was underweight for the length of time she had been in the womb - and she weighed only 1,800 grams when she was born. So, she was a small baby and that made this whole proposition that more serious. It would be serious in anybody but, with a very small baby, especially gestational age baby, which is at high risk for a number of problems, this was important.

So, it was not surprising there was heart failure early on.

To cope with that, what was done was to







Rowe  
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place a band around the pulmonary artery, again, just like a piece of string that was tied moderately tightly. The purpose of that was to raise the resistance in this vessel, which, you remember, leads out to the sponge, which is the lung, to raise the resistance in this vessel to such a degree that it would prevent this waterfall that was going on from the left side to the right at both levels.

So, that operation was the first operation and, unfortunately, that didn't do as much good as one might have hoped and the degree of heart failure progressed to the point where, within a very short time, it became obvious that unless this could be repaired, the baby would not survive. So that a repair was performed by Dr. Trusler, I think, but I'm not absolutely sure of the surgeon's name.

Q. Yes, it was Dr. Trusler.

A. Yes.

And these defects were closed with patches. This defect was closed with a patch and the constricting band in the pulmonary artery, which is applied, of course, on the outside of that artery, was released and the constriction which remained was dilated with suitable instruments so that the size of the artery was restored to, if not the same as it had





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Rowe

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been before, at least very close to it. The baby  
was then returned after that operation to the  
Intensive Care area.

The only other point I want to make  
with this diagram is what is implied by this yellow  
band here.





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A. The yellow band represents the diaphragmatic paralysis. That is the phrenic nerve paralysis that occurred at that time. It was an associated injury to the phrenic nerve at the time of the operation about which I have spoken before, but it had considerable bearing I think on the way this baby behaves.

Q. Thank you, Doctor, very much.  
Indeed when Baby Dawson was in the Hospital for the second operation, that had been earlier in the year in 1980, hadn't it?

A. Yes.  
Q. She had been admitted March 26th and stayed in the Hospital for approximately six or seven weeks and was discharged on May 13th, 1980?

A. Yes.  
Q. She was readmitted July 23rd.  
Can you tell us, Doctor, the reason for her readmission in July?

A. She was discharged I believe back to the hospital in Sudbury.

Q. Yes.  
A. Which I think gives some indication of the difficulties that they had with this





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baby after operation, most of which were not actually connected to the repair problem except in the nature of the diaphragmatic paralysis.

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I understand, although I don't have personal knowledge of the detail, but I understand that the baby had other admissions - may have been discharged from the hospital in Sudbury and then came back in again. Several times this went on back and forth, I think, prior to the transfer because of failure to progress, back to the Hospital.

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Q. Essentially that was the reason for her presenting again at the Hospital for Sick Children on July 23rd, was it not, failure to thrive. She just wasn't getting along very well?

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A. That is right.

15

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Q. She was not growing, gaining weight and so on, and it was a complication as you have said, of the paralysis of the right hemidiaphragm, a phrenic nerve problem.

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18

19

At the time of her admission I understand she had been and was being treated with digoxin and aldactazide.

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Doctor, are those drugs which are classically prescribed for congestive heart failure?

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A. For congestive heart failure, yes.

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Q. And that was one of the problems with this little girl in July, 1980 I take it?

A. She was still on those drugs and I think there was difficulty in being sure there wasn't a heart failure element.

THE COMMISSIONER: Excuse me, what was the other drug?

MR. LAMEK: Aldactazide, Mr. Commissioner.

Q. Perhaps you can just make it clear to us, Doctor, what is aldactazide?

A. Aldactazide is a diuretic combination drug.

Q. Page 87 of the chart which is the medication record, it appears, does it not, that upon her admission to the Hospital for Sick Children on July 23rd the administration of digoxin and aldactazide were continued although she does not appear from this record at least to have received doses of those drugs in the evening of the July 27th.

I wonder, Doctor, can you summarize this baby's course in the Hospital for us from July the 23rd to the 28th when she died?

A. Well, as I have said before I am not the physician of record, but I understand that





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the baby, the problem here was one of growth failure despite the surgical intervention of repair of the defects, and there was a problem with the difficulty breathing which was ascribed to the diaphragmatic paralysis, particularly in relation to the low weight of this baby.

I think the baby was - I think I saw a weight of 3.8 kilograms, and that is not any different from what it was at the time of the discharge previously, and it is way under what one would expect even for a baby of that particular gestational age.

So there was real concern that the baby not growing was a high risk infant, and with the respiratory problem there was concern that would predispose this baby to additional stress from infection in the lung, and that one of the considerations should be to whether or not the right diaphragm should be stabilized so that instead of moving in a paradoxical fashion as these diaphragms do under these conditions, it would be put in a mid position, a neutral position, and not waggle around all the time.

Q. And could that be surgically effected?

A. That can be done surgically.





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Q. Was it proposed that that happen with respect to --

A. I think this was one of the considerations for the transfer of the baby here, although I think it was a total re-evaluation that they had in mind. So that these were the principal issues that had to be addressed: the nutrition of the baby because shortly there wouldn't be any weight left, as it were, and that had to be addressed, and the question of whether surgical treatment of the paralyzed diaphragm would make a difference to the situation.

Q. Well, certainly throughout the progress notes one gleans the message pretty clearly that she was a rather reluctant feeder?

A. Yes, indeed.

Q. But is there anything in the chart, Doctor, with respect to her course in that period that you regard as important in understanding her death and the circumstances in which that death occurred?

A. I think she had an up and down course, lethargic one day, and so on, so that in itself was a reflection of her poor status.

The only thing that I could see







EE.6

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looking through the record was that in the concluding period of her admission she had evidence of early respiratory failure.

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Q. I am sorry, where in particular can I find references to that in the chart, Doctor?

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A. I think the page that I am referring to is at page 83.

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Q. Yes.

A. Which I am not sure whether that is in exact sequence of pages there. It doesn't look as though it is. It looks as though that page follows the resuscitation efforts, but I don't believe that could be possible.

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Q. Well, there is an arrest note on the following page as well, Doctor.

A. What I am really looking for there is the page that should precede page 83. It isn't page 82, and it is not 81 and it is not 80.

It is a note by a Dr. Reynolds, who was a paediatric house officer, paediatric resident.

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Q. Does it bear his name, Doctor?

A. Yes, it does, and on page 83 you can see the name.

Q. Oh, yes.

A. But I recall having seen this





EE.7

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particular record before in this particular area,  
and it was an assessment of the baby at that time,  
and I don't know exactly what the time was.

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Q. Possibly page 86, Doctor?

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The handwriting looks similar.

7

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A. I think you are absolutely

correct. That must be it. Page 86 must be --

9

Q. Should precede page 83?

10

A. Should precede page 83.

11

I think it was because of the fact  
that on the 27th of July the baby had been particu-  
larly lethargic that the matter must have been drawn  
to the attention of the resident.

13

Q. Yes.

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A. By the nurse. And he did a

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review of the situation.

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He was not particularly concerned  
about any question of heart failure. There was no  
fever.

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Q. Yes.

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A. The baby was slightly cyanosed  
and was breathless.

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Q. Yes.

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A. Which probably wasn't hugely

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different from before.

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EE.8

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Q. Yes.

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A. I don't know that he necessarily

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on that account would have been more concerned than  
the possibility that there was either atelectasis or  
heart failure, or at least chest infection, and he  
records the possibility of chest infection.

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Q. Lower down on the page,

8

Doctor, he records a respiration rate of 50.

9

A. Yes.

10

Q. It had not gone up during the

11

day, "but does seem more breathless now ... " than  
something this morning.

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A. Yes.

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Q. Is that the note perhaps you

14

have seen?

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A. You mean "still tachypneic

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60/min"? Are we on page 83?

17

Q. I am on what is page 86. In

18

the lower part of the notes to which you were  
referring there is a further reference to breath-  
lessness which seems more than this morning.

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A. Yes. I am sorry. Although

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the respiratory rate I take it does not increase  
during the day --

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Q. Yes.

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A. That is a little bit discordant, but at any rate he had some feel that there was something going on here in the chest so he decided to start antibiotics, to start intravenous. I don't recall whether it was started, and to have hourly assessment of this baby.

He also got some blood gases done.

Q. Yes.

A. And I think the blood gas is the significant factor of that examination. I think it was an appropriate decision on the part of the house officer but I think the value of the PCO2 that is circled there is the carbondioxide level in the blood which was 62, and that is well above the normal range and implies that there is retention of carbon-dioxide and that is usually an implication that the lungs aren't working; not working well anyhow.

So I think that is the only part of the examination - one is a little uncertain of what the diuresis after the lasix might mean. It might be implied that there is some degree of heart failure too, and I think that demonstrates some of the difficulties that did exist with this baby, that the breathlessness was difficult to dissociate perhaps from some effect on the cardiac function - effect







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from the cardiac function as well as the paralyzed diaphragm.

Q. Yes.

A. It really wasn't very well clarified.

Q. To what stage was consideration taken of readmitting this child to the operating room for correction or repair of the paralyzed diaphragm?

A. I am not sure of that. I don't know the answer to that. I think the person who would be able to clarify that I think would be Dr. Vera Rose.

Q. All right. And the antibiotics being started on the 27th I take it suggest a suspicion or perhaps a precaution against the possibility of infection?

A. Yes. I think if there is a question in a debilitated baby of this sort you cannot wait for a confirmation. You have to treat it and then it will perhaps be shown not to be an essential but one wouldn't want to take a chance.

Q. But appropriate action appears to have been taken on the 27th in light of the observation then made?

A. I think so. The question of what might have been done further about the respiratory





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situation in terms of ventilation could be raised but I think that would be something we would have to ask the doctors at the time because there was no indication there that I can see that they raised that matter further.

Q. Doctor --

A. I am sorry, I missed a point on the chart.

Q. Yes, which page, Doctor?

A. This is page 84, the top of page 84.

Q. Yes.

A. The question that is asked is:

"How much of this is due to a paralyzed right diaphragm needs surgical/respiratory consults and gases tomorrow",

so I think the resident was thinking about it and must have discussed this with the cardiologist and this must have been a decision that, well, let's see how things were the next morning.

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Q. Yes.

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Doctor, you reviewed the course of the child and it was not all plain sailing, of course. Was there anything in the course that you have looked at that is disclosed in the record over the period from the 23rd to the 27th of July that would lead you to believe that Amber Dawson was at risk of imminent death?

A. No. But I would qualify that. This sort of baby with evidence of respiratory failure developing is a high risk for deterioration. But I would think it fair to say that, hopefully, that could be managed.

Q. Now, page 80 of the chart, doctor, the last note before the arrest note in the middle of the page dated July 27, 1980, it is in the middle of two arrest notes, as a matter of fact, covering the period from 7:00 p.m. until 1:30 in the morning, and it is a note by Nurse Nelles.

Incidentally, when we were referring to the last case and I said I guess we have to ask Nurse Nelles about that, the note, of course, was a note of Mrs. Traynor.

A. Yes.

Q. This is Nurse Nelles' note cover-







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ing the period from 7:00 p.m. on the 27th to 1:30 a.m.  
in the morning of July 28th:

"Chest slightly noisy in the upper  
lobes. Respirations appear laboured  
at times, up to 62 at midnight. Apex  
pulse is 130/106 and regular. Be-  
haviour continues to be lethargic.  
Nutrition - Dr. Reynolds notified re  
baby's poor nutritional status and  
lethargy. Blood work done and IV  
started in scalp vein at 22:00."

I can't read the next line, I'm afraid.

"...post-lasix voids, 235 ccs for a  
total output of 267 cc."

Not a particularly well baby, I take it,  
doctor, but no substantial change from what we have  
been reading through the week in the chart there, is  
it?

A. I think this was at the time  
when Dr. Reynolds did his examination and the blood  
gases are --

Q. Ah, yes, the blood gases in the  
chart, the note itself is not --

A. No.

Q. I'm sorry, you're quite right.





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But then at 1:30 in the morning,  
Nurse Nelles records:

"Apex noted to be dropping..."

THE COMMISSIONER: That is at 9:30,  
isn't it? Is that 1:30?

MR. LAMEK: I believe that to be  
01:30, Mr. Commissioner.

THE COMMISSIONER: It looks to me to  
be 21:30, but perhaps I am wrong. They haven't  
changed the date.

MR. LAMEK: No, the date isn't  
changed but you will notice, Mr. Commissioner, the  
date isn't changed and there is a similar uncompleted  
zero at the head of the previous note, which goes  
19:00 to 01:30, I believe.

THE COMMISSIONER: Oh, yes.

MR. LAMEK: Q. "Apex noted to be  
dropping. Rate 79 and falling.

Dr. Reynolds notified. Respirations  
about 50 at the time the apex is  
noted and quite laboured. Baby  
started to gag and showed some seizure  
activity. Code 25 called and cardio-  
pulmonary resuscitation initiated."

It then refers to the physician's notes.





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Then there are two notes, I believe, and, doctor, maybe you can help me as to why that should be; perhaps two doctors were present at the resuscitation.

At the top of that page, under date 28.7.80, is a note by Dr. Izakawa, whom we identified this morning, and a brief summary of the patient and the history, of course. At the end of his note, 1:55 a.m.:

"Extreme bradycardia. Resuscitative measures started without success. After 45 minutes stopped."

And at page 84, there is a further note of the arrest and the resuscitation effort by an Associate Resident, whose name, I confess, I cannot read, but it is dated 28.7.80, at 01:47:

"Increasing respiratory distress during evening. PCO2 up 62. Sudden recent deterioration to collapse. Initial condition, gasping spontaneous respirations. Extreme bradycardia. Bag ventilation and external cardiac massage commenced. IV given."

It lists the drugs that were given, indicating no response to those drug administrations and:

"50 minutes no return of any electrical





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activity. Resuscitation discontinued  
on advice of Dr. Izukawa."

Who apparently was there at the time.

A. Yes.

Q. So, recognizing the significance  
that you attach to the blood gases information taken  
in the evening of the 27th, what we have objectively,  
I suggest again, is at 1:30 in the morning a sudden  
drop in the heart rate. We have got some gagging  
that is recorded, seizure activity, Code 25 called;  
all things followed shortly by extreme bradycardia  
and the child cannot be resuscitated and is pronounced  
dead.

Now, in terms of the onset and course  
of the terminal events, doctor, is that not essentially  
the same picture that we saw five times yesterday and  
once this morning?

A. It is similar.

Q. The same activity and occurrences  
seem to be present and, other than the blood gases  
to which you have drawn our attention, I believe, if  
you would help me a little bit further with that as  
to the significance. Is the picture that seems to  
emerge from the chart that of an unwell child who  
seemed to be tottering along with no particular







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FF6 2 episodes of crisis but not a well child and then  
3 suddenly goes into a rapid and apparently irreversible  
4 deterioration?

5 A. Yes.

6 Q. Now, to what extent does the  
7 blood gas information distinguish this situation from  
8 any of the others that we have looked at with a  
9 similar course of terminal events?

10 A. It just implies that the respira-  
11 tory function of the baby is bad and that would be,  
12 I guess, particularly significant with a baby whose  
13 respiratory rate has gone up, because when you are  
14 breathing faster, you blow off more carbon dioxide.

15 Q. Yes.

16 A. So, if it doesn't blow off when  
17 you are breathing fast, you are in real trouble. So,  
18 I think there is a considerable concern in that this  
19 respiratory functioning may have been accounting for  
20 some of this deterioration.

21 Q. Yes.

22 A. I don't know that we can be  
23 sure that was the entire picture.

24 Q. Dr. Rowe, what in your judgment  
25 was the reason for, or the explanation of the sudden  
and rapid decline in Amber Dawson's case? I'm sorry,





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why did Amber Dawson die when and in the way that she did?

A. I don't think we can be absolutely sure.

Q. And that, I take it, is why this is one of the cases that was reported to the Coroner?

A. I believe that is so.

Q. Could you turn to page 66.

Did you participate in the decision to report this case to the Coroner?

A. No.

Q. Page 66, is that extract from the Coroner's Act that I understand appears on the back of the Coroner's Office form of Post Mortem Report?

Do you know under which clause of Section 9(1) this case was reported? Was it reported I would not have thought under (a); it was not thought to be a case of violence, misadventure or negligence?

A. No.

Q. Or misconduct or malpractice?

A. No.

Q. It wasn't a matter of pregnancy or unfair means.

Do you know whether it was reported because it was considered to be a death that occurred





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suddenly and unexpectedly or:

"(g) under such circumstances as may  
require investigation."

Why was it considered a Coroner's  
death?

A. I am not absolutely sure. I  
think we would have to ask the cardiologists involved.  
I think that Dr. Izukawa and Dr. Olley were the two  
people involved with that family. I would personally  
think that there are good medical reasons why the  
baby might have died - respiratory difficulty,  
respiratory failure in a chornically ill baby. I  
think it is a borderline situation for reporting to  
the Coroner, but I think that perhaps it was a wise  
decision to do so.

Q. At page 63 of the record, which  
is part of the Coroner's Act Form of Post Mortem  
Report, under "Cause of Death", the information is  
supplied by the pathologist, who is Dr. Cutz of the  
Hospital For Sick Children, is he not?

A. Yes.

Q. "The immediate anatomical cause  
of death not determined."

However, he does give:

"(contributing factors: congenital







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FF9 2 heart disease, right hemidiaphragm  
3 paralysis)." 4

5 Even at autopsy, Dr. Cutz could not  
6 identify something that he could say with any confi-  
7 dence was the anatomical cause of death; is that  
8 correct? 9

10 A. Yes. I believe he did find some  
11 perforation in the stomach. 12

13 Q. That's true. And Dr. Bain had  
14 something to say about that, did he not? 15

16 A. Yes. 17

18 THE COMMISSIONER: That is Exhibit...? 19

20 MR. LAMEK: I'm afraid I'm not very  
21 good at remembering numbers, Mr. Commissioner. 22

23 Mr. Registrar, the number of Dr. Bain's  
24 report? 25

THE REGISTRAR: 48, I think it is.

MR. LAMEK: Yes.

Q. Dr. Bain said of this baby:

"She was placed in this category..."

That is the one on which <sup>he</sup> ~~you~~ wanted to comment:

"...for several reasons. She was  
almost a year old. She had had open  
heart surgery at age nine months.  
Following this she had a paralyzed





Rowe  
dr.ex. (Lamek)

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diaphragm and had had several hospital admissions, required digoxin and diuretics to keep her out of heart failure. However, her general condition, although poor, was stable until about the day before her arrest. At this time, her respirations became rapid and laboured.

At autopsy, there was softening of the upper end of the stomach with actual perforation, which they felt was precipitated by vomiting. A lung was collapsed.

I feel it is virtually certain that the perforation of the stomach was sufficient to trigger her cardiac arrest in her poor condition."

Now, doctor, do you agree with Dr. Bain's assessment that the stomach perforation, apparently caused by her, or presumably caused by vomiting, was sufficient to trigger her cardiac arrest?

A. That is a possibility.

Q. Is it virtually certain?

A. I don't think I can say that.

Q. And the difference between you and





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Dr. Bain then, the difference --

A. One of degree.

Q. -- is the difference in confidence level?

A. Yes. He is a much more skilled pediatrician than I ever was. So, I would be prepared to accept his comment.

Q. Doctor, that is very gracious of you. We will have to ask you about his comment. Your own view would be something less than virtually certain that that would trigger the arrest?

A. Yes.

Q. Now, as of January 12, 1981, Amber Dawson's death was one of the those I recall that you did find as unexpected, according to your definition of that term?

A. Yes.

Q. Was it not?

A. Yes.

Q. As of January 12, 1981, did you have any explanation for Amber Dawson having died when and in the manner that she did?

A. I think it was felt that the cause of death was respiratory in the conclusions and that this was due to the fact that she was so wasted





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and in poor status that what might otherwise, for a baby, have been something that could have been weathered, for this particular infant, weighing what she did at the age she was, that could explain the death.

Q. It could explain the death.

Fairly, doctor, and as I am understanding you, there is still an air of doubt about the cause of this baby's death?

A. Yes.

Q. The direct cause of her death.

A. Yes.

Q. Doctor, it may not have occurred to you at the time but were Amber Dawson's terminal events and the course of those events consistent with digoxin intoxication?

A. Yes.







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Q. Did that occur to you as a possible explanation of this death?

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A. No.

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Q. Has it since occurred to you as a possible explanation of this death?

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A. Not since the preliminary hearings and the circumstances surrounding the...

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Q. I'm sorry?

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A. Not since the circumstances surrounding this whole investigation.

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Q. I don't understand you.

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A. Well, because of the consideration given to these babies by all the analyses that have been done since the whole matter became under the aegis of the police.

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Q. Do you say it has not occurred to you that that is a possible explanation of Amber Dawson's death or that it has occurred to you, I'm sorry?

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A. It has occurred to me.

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Q. Oh, it has occurred to you.

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A. Yes.

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MR. LAMEK: Mr. Commissioner, is this an appropriate time to adjourn for the day?

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THE COMMISSIONER: Yes.

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MR. LAMEK: Indeed, for the week.

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THE COMMISSIONER: Yes, yes until --  
anyone, no problems then?

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MR. BOGART: Yes, Mr. Commissioner,  
just one question. Do we now have all the medical  
records that Mr. Lamek intends to deal with in this  
first segment of Dr. Rowe's evidence?

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THE COMMISSIONER: The answer to that  
is no because I guess that is because they aren't  
all done yet, is that right?

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MR. LAMEK: They were not at the  
time I left this morning. I am certainly prepared to  
do this if I can, Mr. Commissioner. I will call  
counsel or have counsel called tomorrow if possible,  
if not on Monday morning, to let them know that  
additional charts will be available to be picked up  
at the Commission's office.

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THE COMMISSIONER: Will we all be  
arrested under the Krever rules though?

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MR. LAMEK: I'm sorry?

THE COMMISSIONER: Will we all be  
arrested under the Krever rules?

MR. LAMEK: Oh, that's right, we  
should be marking them, shouldn't we.





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2 THE COMMISSIONER: We will all be  
3 arrested for distributing these.

4 MR. LAMEK: Well, certainly we will  
5 not be on to any -- well, we will be on to new ones,  
6 I'm sorry. Maybe we will just have to do our best  
7 with the new material that is going to come into  
8 counsel hands on Tuesday.

9 THE COMMISSIONER: We haven't any-  
10 thing available here we could put to the witness.  
11 That's a problem you see, we can't really distribute  
12 them.

13 MR. LAMEK: Yes.

14 ~~THE WITNESS:~~ *Commissioner* But I tell you what is  
15 going to happen at any rate. Mr. Lamek has revealed  
16 to me that it is touch and go whether he is even going  
17 to finish on Tuesday with this witness. So that  
18 at least you will have that time frame and more.

19 MR. BOGART: That was going to be  
20 my next question, sir. Thank you very much.

21 THE COMMISSIONER: Well, I think that  
22 that's it, but certainly you will want time to  
23 consider these reports. Yes, Miss Symes?

24 MS. SYMES: Yes, Mr. Commissioner,  
25 perhaps I could ask Mr. Lamek. We have started now  
through the list of deaths. Is it your intention to







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put to Dr. Rowe all 46 deaths?

MR. LAMEK: No, not at this time.

Mr. Commissioner, what I propose to do with Dr. Rowe at this stage is to lead his evidence as to the reviews of death which he conducted prior to the explosion of public suspicion about the question of digoxin. What I want from Dr. Rowe, if I can have it at this time, is the impressions and judgments that he formed of these deaths before digoxin became a public issue and a matter of public suspicion.

Now, I understand that at a later stage Dr. Rowe reviewed later deaths in some detail and indeed went back and reviewed some of these deaths that he has already talked about.

THE COMMISSIONER: What ones are those, what babies?

MR. LAMEK: I'm sorry.

THE COMMISSIONER: Can you tell us what babies you are going to put to him?

MR. LAMEK: Yes, they are those that are listed on the last page of the minutes of January 12th, subject to the ---

THE COMMISSIONER: So, it is only the babies that died up until January?





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MR. LAMEK: Until the end of the year,  
really.

THE COMMISSIONER: Yes.

MR. LAMEK: And then I will hope to  
have Dr. Rowe back at a later stage to talk about  
the reviews that he subsequently did when there was  
a rather different atmosphere about.

THE COMMISSIONER: So, if that helps  
you, Miss Symes.

MS. SYMES: Yes.

THE COMMISSIONER: The babies up  
until January. Yes, Mr. Strathy?

MR. STRATHY: I wonder if I could  
ask for some further assistance from Mr. Lamek.  
There have been several occasions during this  
Commission, during the course of the Doctor's  
evidence that he has suggested Dr. Freedom should  
be approached and we have also now had put in evidence  
Dr. Bain's report and he comments on a number of  
the deaths. I'm just wondering, is it Mr. Lamek's  
intention to call Dr. Freedom and Dr. Bain?

MR. LAMEK: It most certainly is.

THE COMMISSIONER: Yes.

MR. LAMEK: Dr. Freedom I gather is  
not going to be available for the balance of this





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2 month but that may be an entirely academic considera-  
3 tion anyway.

4 Dr. Bain will be available at a  
5 later stage and I do propose to call him to give  
6 evidence as to the matters contained in his report  
7 and the impressions he formed, recognizing that that  
8 was a review that was made after the Preliminary  
9 Inquiry had been completed, at a time when Dr. Bain  
10 did have access, albeit only through the information  
11 at the Preliminary Inquiry, to certain information  
12 relating to digoxin levels.

13 Yes, Dr. Bain will be called and it  
14 is my intention to call Dr. Freedom as well.

15 MR. SCOTT: Mr. Commissioner, do I  
16 understand then that Mr. Lamek expects to finish his  
17 examination in chief on Tuesday?

18 MR. LAMEK: No, the Commissioner has  
19 said perhaps kindly that it is touch and go whether I  
20 will.

21 MR. SCOTT: I didn't know whether that  
22 was facetious or realistic.

23 THE COMMISSIONER: I hope it is more  
24 go than touch. I would hope that he would finish.

25 MR. LAMEK: I will do my best.

THE COMMISSIONER: Yes.







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MR. SCOTT: So, that is a realistic objective? I mean, we are talking about finishing on Tuesday or Wednesday and beginning cross-examination?

MR. LAMEK: Tuesday or Wednesday, yes.

THE COMMISSIONER: And we will begin the cross-examination then and whether we will finish the cross-examination before the end of next week I think is also touch and go and probably more unrealistic than realistic, I don't know.

All right then, until Tuesday at 10 o'clock.

MR. LAMEK: Tuesday at 10:00, sir.

---Whereupon the hearing adjourned until Tuesday, July 19th, 1983 at 10:00 a.m.







